

**CDC's Emerging Infections Program  
CDC/USDA/FDA Foodborne Diseases Active Surveillance Network  
Steering Committee Conference Call**

Date: Thursday, October 14, 2004  
Time: 2:00-3:00 EDT  
Numbers: Number: 877-601-3547 PassCode: 14349

**A. Administrative**

1. EIP conference call coordination
2. Personnel
  - a. Good-bye to Nicole Ishill (CDC)
3. Status of manuscripts
  - a. Active/Published
  - b. Addition of state-specific manuscripts to line list
4. Site Visits
  - a. Texas (September 13, 2004)
  - b. University of Minnesota (September 30, 2004)
5. EIP Applications

**B. Surveillance**

1. Status of 2003 Annual Report
2. Active/HUS/Outbreak data
3. Data transmission via EIP FTP

**C. Update on case-control studies**

1. *Listeria* (Fred Angulo)
2. *Salmonella* Newport (Fred Angulo)
3. *Salmonella* Enteritidis (Ruthanne Marcus)
4. Infant *Salmonella*/*Campylobacter* (Tim Jones)
5. *E. coli* O157/HUS (Fred Angulo/John Dunn)

**D. Update on Working Groups**

1. HUS/O157 (Kirk Smith/Ruthanne Marcus)
  - a. Serum collection and testing
  - b. HP2010 Objective
2. Interventions (Pat Ryan)
3. Outbreak/Norovirus (Tim Jones)
4. Coordinators (Jennifer Nelson)
5. Attributions (Paul Cieslak)
6. Int'l Collaboration on Foodborne Diseases (Elaine Scallan)
7. Burden (Elaine Scallan)

**E. Proposals**

1. Evaluating the reporting of contributing factors (CF) to EFORS (Craig Hedberg)

**F. Upcoming FoodNet conference calls, meetings, and deadlines**

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|---------------|-----------------------|--------------------|--|
| 1. Wednesday  | Oct. 13 <sup>th</sup> | 1:00-2:00 pm EDT   | <i>Campylobacter</i> —Lab Survey Subcommittee    |
| 2. Thursday   | Oct. 14 <sup>th</sup> | 12:00-1:00 pm EDT  | HUS/STEC Working Group call                      |
| 3. Monday     | Oct. 18 <sup>th</sup> | 12:30-1:30 pm EDT  | Reactive Arthritis study call                    |
| 4. Monday     | Oct. 18 <sup>th</sup> | 1:00-2:00 pm EDT   | <i>Shigella</i> Working Group call               |
| 5. Monday     | Oct. 18 <sup>th</sup> | 2:00-3:00 pm EDT   | Infant case-control study call                   |
| 6. Monday     | Oct. 18 <sup>th</sup> | 2:30-3:30 pm EDT   | GBS Working Group call                           |
| 7. Monday     | Oct. 18 <sup>th</sup> | 3:30-4:30 pm EDT   | Modeling Subcommittee call                       |
| 8. Thursday   | Oct. 21 <sup>st</sup> | 3:00-4:00 pm EDT   | Outbreak Working Group call                      |
| 9. Tuesday    | Oct. 26 <sup>th</sup> | 2:00-3:00 pm EDT   | Interventions Working Group call                 |
| 10. Wednesday | Oct. 27 <sup>th</sup> | 1:00-2:00 pm EDT   | <i>Campylobacter</i> —Lab Survey Subcommittee    |
| 11. Wednesday | Oct. 27 <sup>th</sup> | 1:00-2:00 pm EDT   | <i>Campylobacter</i> —Grocery Store Subcommittee |
| 12. Thursday  | Oct. 28 <sup>th</sup> | 8:00-9:00 am EDT   | Int'l Collaboration on Foodborne Disease         |
| 13. Thursday  | Oct. 28 <sup>th</sup> | 1:00-2:00 pm EDT   | Antimicrobial Resistant Working Group call       |
| 14. Thursday  | Oct. 28 <sup>th</sup> | 2:00-3:00 pm EDT   | FoodNet Coordinators call                        |
| 15. Thursday  | Oct. 28 <sup>th</sup> | 3:00-4:00 pm EDT   | Infant Illness Working Group call                |
| 16. Tuesday   | Nov. 2 <sup>nd</sup>  | 2:00-4:00 pm EST   | November Update meeting                          |
| 17. Wednesday | Nov. 3 <sup>rd</sup>  | 3:30-4:30 pm EST   | Validation of Multipliers Working Group call     |
| 18. Thursday  | Nov. 4 <sup>th</sup>  | 11:00-12:00 pm EST | Attribution Working Group call                   |
| 19. Thursday  | Nov. 4 <sup>th</sup>  | 2:00-3:00 pm EST   | November Steering Committee call                 |
| 20. Wednesday | Nov. 10 <sup>th</sup> | 4:00-5:00 pm EST   | Burden Working Group call                        |

**G. Data Submission Deadlines**

1. Surveillance data transmission Friday, October 15<sup>th</sup>
2. HUS data transmission Wednesday, October 27<sup>th</sup>

## Active FoodNet Manuscripts

Status	ID	Lead	Co-authors	Manuscript Title	Date Last Corr.	Comments
<b>6</b>						
	89	Dunne, Eileen (CDC)	JC Lay, B Shiferaw, JB Bender, ZF Dembek, Davis, LG Wesolowski, S Zansky, M Carter, EJ Boothe, S Burnite, F Hardnett, J Wells, B Bibb, PM Griffin, P Mead	Results of active surveillance for pediatric Hemolytic Uremic Syndrome (HUS) in the United States, 1997-1999	9/3/2004	Submitted to JAMA
	91	Schroder, Carl (USDA)	AL Naugle, WD Schlosser, AT Hogue, FJ Angulo, E Ebel, JS Rose, WT Disney, K Holt, DP Goldman.	Estimated illnesses from Salmonella Enteritidis in shell eggs, United States, 2000	6/8/2004	Submitted to EID on April 26, 2004. Under editorial review.
	93	Scallan, Elaine (CDC)	SE Majowicz, G Hall, A Banerjee, CL Bowman, L Daly, T Jones, MD Kirk, M Fitzgerald, FJ Angulo	Prevalence of diarrhea in the community in Australia, Canada, Ireland and the United States	8/4/2004	Accepted at International Journal of Epidemiology
	94	Jones, Tim F (TN)	SN Bulens, S Gettner, RL Garman, DJ Vugia, D Blythe, MA Hawkins, SS Monroe, FJ Angulo, UD Parashar	Use of Stool Collection Kits Delivered to Patients Can Improve Confirmation of Etiology in Foodborne Disease Outbreaks	7/8/2004	In press with CID
	95	Green, Laura (CDC)	C Selman, FJ Angulo, V Radke, S Buchanan and the EHS-Net Working Group	Food service workers' self-reported food preparation practices: an EHS-Net study	6/8/2004	Has been requested for special issue; publication date unknown.
	148	Haber, Penina (CDC)	F DeStefano, FJ Angulo, J Iskander, S Shadomy, E Weintraub, RT Chen, and the VAERS Team	Guillain-Barre Syndrome (GBS) after influenza vaccine: Vaccine Adverse Event Reporting System (VAERS) 1990-2003	10/4/2004	Submitted to JAMA
	149	Varma, Jay (CDC)	K Molbak, S Rossiter, M Hawkins, T Jones, S Mauvais, T Rabastsky-Ehr, S Stenzel, D Vugia, M Park, K Joyce, K Stamey, H Chang, F Angulo, and the EIP FoodNet Working Group	Antimicrobial resistance in Salmonella is associated with increased hospitalization; NARMS 1996-2000	9/1/2004	Accepted at JID
<b>5</b>						
	87	Samuel, Michael (CA)	DJ Vugia, KM Koehler, R Marcus, AA McNees, V Deneen, B Damaske, B Shiferaw, J Hadler, FJ Angulo	Consumption of risky foods among adults at high risk for severe foodborne diseases: room for improved targeted prevention messages	9/1/2004	Returned from CDC clearance; author incorporating comments. Has been cleared by FDA.
	88	Koehler, Kathleen (FDA)	T Lasky, SB Fein, SM DeLong, MA Hawkins, T Rabastsky-Ehr, SM Ray, B Shiferaw, E Swanson, and DJ Vugia for the EIP FoodNet Working Group	Population-based incidence of infection with selected enteric bacterial pathogens for children < 5 years of age, FoodNet, 1996-1998	7/2/2004	Revised version is in CDC clearance.

\*Status: 0=Proposal, 1=Analysis, 2=Writing, 3=Draft being reviewed by co-authors, 4=Incorporating comments, 5=NCID/CDC clearance, 6=At journal/In press, 7=Published

## Active FoodNet Manuscripts

Status	ID	Lead	Co-authors	Manuscript Title	Date Last Corr.	Comments
	150	Green, Laura (CDC)	C Selman, T Jones, E Scallan, R Marcus, and the EHS-Net Population Survey Working Group	Beliefs about sources of gastrointestinal illness	8/4/2004	
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<b>4</b>						
	85	Kennedy, Malinda (CDC)	T Rabatsky-Her, S Lance-Parker, S Thomas, K Smith, J Mohle-Boetani, B Keene, P Mead.	Changes in bovine risk factors for E. coli O157: a case-control study in FoodNet sites: 1999-2000	9/3/2004	Revising based on Paul's comments.
	90	Watt, JP (CDC)	M Bales, AL Dannenberg, B Imhoff, SR Mullins, SF Dowell	Impact of a health-related internet hoax on a public health agency and the public: implications for health communication	2/27/2004	
	157	Devasia, Rose (TN)	JK Varma, JM Whichard, S Gettner, AB Cronquist, S Hurd, SD Segler, KE Smith, D Hoefer, B Shiferaw, FJ Angulo, TF Jones, and the EIP FoodNet Working Group	Health consequences of infection with multidrug resistant and pan-susceptible Salmonella Newport reported to FoodNet--United States, 2002-2003	9/3/2004	Need to revise numbers; submit to co-authors
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<b>3</b>						
	86	Patrick (Evans), M (DeKalb Co. Health Dept)	PM Griffin, PS Mead	The effectiveness of recall notification: community response to a nationwide recall of hot dogs and deli meats	6/8/2004	Waiting on comments from Paul; should be submitted to clearance within the month of June
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<b>2</b>						
	3	Varma, Jay (CDC)	R Marcus, SA Stenzel, SA Hanna, S Gettner, BJ Anderson, T Hayes, B Shiferaw, TL Crume, K Joyce, FJ Angulo for the EIP FoodNet Working Group	Risk factors for infection with multi-drug resistant Salmonella serotype Newport – United States, 2002-2003	6/8/2004	Anaylsis proceeding
	80	Varma, Jay (CDC)	MC Samuel, R Marcus, M Hoekstra, C Medus, S Segler, BJ Anderson, TF Jones, B Shiferaw, N Haubert, M Megginson, PV McCarthy, W De Witt, T Van Gilder, and the EIP FoodNet Working Group	Listeria monocytogenes infection from food in the regulatory era: a case-control study of risk factors for sporadic illness in the United States	9/3/2004	Draft to Fred for review
	82	Malone, Shauna (CT)	R Marcus, J Hadler, S Zansky, D Hoefer,	Knowledge, attitude, and practice of the use of irradiation among respondents to the FoodNet Population Survey in Connecticut and New York		
	84	Vugia, Duc (CA)	FoodNet Education Working Group	Foodborne diseases in the United States: lessons learned from FoodNet, 1996-2002	6/8/2004	

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Status	ID	Lead	Co-authors	Manuscript Title	Date Last Corr.	Comments
	158	Cheung, Michele (CA)	S Ray, B Shiferaw, N Vik, T Rabatsky-Ehr, E Boothe, M Kennedy, T Lasky, D Vugia	Foodborne pathogens causing illness in the first 7 days of life: FoodNet, 1996-2001	8/4/2004	Data is being reviewed again and a manuscript is being drafted
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<b>1</b>						
	1	Marcus, Ruthanne (CT)	MR Moore, JK Varma, C Medus, T Crume, R Marcus, SM Zansky, E Boothe, D Boxrud, RV Tauxe, and the EIP FoodNet Working Group	Risk factors for sporadic infection caused by Salmonella Enteritidis in the United States, 2002-2003	7/2/2004	
	81	Voetsch, Drew (CDC)	TBD	Analysis of trends in listeriosis in the FoodNet sites, 1996-2003	7/14/2004	Proposal was originally submitted/approved by Matt Moore; this is a resubmission.
	152	Frenzen, Paul (USDA-ERS)	A Drake, others TBD	The economic cost of E. coli O157:H7 infections	7/14/2004	Proposed submission to J. Food Protection
	153	Drake, Alison (CDC)	TBD	E. coli O157 and HUS infections, 1997-2002	9/3/2004	
	160	Frenzen, Paul (USDA-ERS)	TBD	Consumer interest in irradiated foods	8/9/2004	
	161	Bowen, Anna (CDC)	C Braden, C McDonald	Invasive E. sakazakii infections among infants	8/9/2004	
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<b>0</b>						
	2	Kretsinger, Katrina (CDC)	J Crump, K Joyce, D Vugia, M Megginson, S Segler, S Hurd, J Luedeman, B Shiferaw, S Hanna, J Stevenson, F Angulo	Clinical consequences of typhoid fever due to Salmonella Typhi with decreased susceptibility to ciprofloxacin		
	4	Beach, Michael (CDC)	TBD	H20 manuscript		

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Status	ID	Lead	Co-authors	Manuscript Title	Date Last Corr.	Comments
	5	Jones, Tim F (TN)	TBD	Infant Salmonella case-control study		
	6	Snider, Cindi (CDC)	TBD	Descriptive characterization of adult HUS in FoodNet sites, 1997-2002	2/9/2004	
	7	Majowicz, Shannon (Health Canada)	E Scallan, G Hall, A Banerjee, MD Kirk, F Angulo	Respiratory symptoms among persons with gastrointestinal illness		
	8	Jones, Tim F (TN)	E Scallan, M McMillian, P Frenzen, N Ishill, A Cronquist, S Thomas, F Angulo	Diarrhoeal illness in FoodNet: cycles 1-4 of the population survey		
	9	Scallan, Elaine (CDC)	T Jones, M McMillian, P Frenzen, N Ishill, A Cronquist, S Thomas, F Angulo	Respiratory symptoms among persons with diarrhea in FoodNet sites		
	71	Nelson, Jennifer (CDC)	TBD	Multiple pathogens isolated over a short period, FoodNet 1996-2002		
	162	Scallan, Elaine (CDC)	P Frenzen, others TBD	The economic cost of diarrheal illness in the United States		
	163	Scallan, Elaine (CDC)	The FoodNet Burden Working Group	Bacterial foodborne illness in the United States		
	165	Dunn, John R (CDC)	TBD	Substantial decline in the incidence of Escherichia coli O157:H7 infections in FoodNet, 2003		
	166	Ailes, Elizabeth (CDC)	J Nelson, other TBD	Foodborne Diseases Active Surveillance Network Surveillance Summary, 1996-2003		

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## Active FoodNet Manuscripts

Status	ID	Lead	Co-authors	Manuscript Title	Date Last Corr.	Comments
	167	Cronquist, Alicia (CO)	E Scallan, others TBD	Health care utilization among persons who have recently experienced gastrointestinal illness		
	168	Fullerton, Katie (CDC)	TBD	Infant Campylobacter case-control study		

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## Published FoodNet Manuscript

Lead	Co-authors	Title	Citation/Web Link
<b>2004</b>			
Allos, Ban Mishu (TN)	MR Moore, PM Griffin, RV Tauxe	Surveillance for Sporadic Foodborne Disease in the 21st Century: The FoodNet Perspective	Clinical Infectious Diseases, 2004;38:S115-S120 <a href="http://www.cdc.gov/foodnet/pub/CID/allosb.pdf">http://www.cdc.gov/foodnet/pub/CID/allosb.pdf</a>
Bender, Jeffrey B (CDC)	KE Smith, AA. McNees, TR Rabatsky-Ehr, SD Segler, MA Hawkins, NL Spina, WE Keene, MH Kennedy, TJ Van Gilder, CW Hedberg, for the Emerging Infections Program (EIP) FoodNet Working Group	Factors Affecting Surveillance Data of Escherichia coli O157 Infections Collected from FoodNet Sites, 1996-1999	Clinical Infectious Diseases, 2004;38:S157-S164 <a href="http://www.cdc.gov/foodnet/pub/CID/benderj.pdf">http://www.cdc.gov/foodnet/pub/CID/benderj.pdf</a>
Centers for Disease Control and Prevention	FoodNet Working Group	Preliminary FoodNet Data on the Incidence of Pathogens Transmitted Commonly Through Food - Selected Sites, United States, 2003	MMWR April 30, 2004/53(16);338-343 <a href="http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5316a2.htm">http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5316a2.htm</a>
Chatterjee, Nando K (NY)	DW Moore, SS Monroe, RI Glass, MJ Cambridge, SF Kondracki, and DL Morse	Molecular Epidemiology of Outbreaks of Viral Gastroenteritis in New York State, 1998-1999	Clinical Infectious Diseases, 2004;38:S303-S310 <a href="http://www.cdc.gov/foodnet/pub/CID/chatterjeen.pdf">http://www.cdc.gov/foodnet/pub/CID/chatterjeen.pdf</a>
Friedman, Cindy R (CDC)	RM Hoekstra, M Samuel, R Marcus, J Bender, B Shiferaw, S Reddy, SD Ahuja, DL Helfrick, FP Hardnett, M Carter, B Anderson, RV Tauxe, for the Emerging Infections Program (EIP) FoodNet Working Group	Risk Factors for Sporadic Campylobacter Infections in the United States: A Case-Control Study in FoodNet Sites	Clinical Infectious Diseases, 2004;38:S285-S296 <a href="http://www.cdc.gov/foodnet/pub/CID/friedmanc.pdf">http://www.cdc.gov/foodnet/pub/CID/friedmanc.pdf</a>
Glynn, M. Kathleen (CDC)	V Reddy, L Hutwagner, T Rabatsky-Ehr, B Shiferaw, DJ Vugia, SD Segler, J Bender, TJ Barrett, FJ Angulo, for the Emerging Infections Program (EIP) FoodNet Working Group	Prior Antimicrobial Agent Use Increases the Risk of Sporadic Infections with Multidrug-Resistant Salmonella enterica Serotype Typhimurium: a FoodNet Case-Control Study	Clinical Infectious Diseases, 2004;38:S227-S236 <a href="http://www.journals.uchicago.edu/CID/journal/issues/v38nS3/32118/32118">http://www.journals.uchicago.edu/CID/journal/issues/v38nS3/32118/32118</a>
Gupta, Amita (CDC)	JM Nelson, TJ Barrett, RV Tauxe, SP Rossiter, CR Friedman, KW Joyce, KE Smith, TJ Jones, MA Hawkins, B Shiferaw, JL Beebe, DJ Vugia, T Rabatsky-Her, JA Benson, TP Root, FJ Angulo for the NARMS Working Group	Antimicrobial Resistance Among Campylobacter Strains in the United States, 1997-2001: Increasing Prevalence of Ciprofloxacin Resistance	Emerging Infectious Diseases, Vol. 10, No. 6, January 2004 <a href="http://www.cdc.gov/ncidod/eid/vol10no6/03-0635.htm">http://www.cdc.gov/ncidod/eid/vol10no6/03-0635.htm</a>
Hardnett, Felicia P (CDC)	RM Hoekstra, M Kennedy, L Charles, FJ Angulo, for the Emerging Infections Program (EIP) FoodNet Working Group	Epidemiologic Issues in Study Design and Data Analysis Related to FoodNet Activities	Clinical Infectious Diseases, 2004;38:S121-S126 <a href="http://www.cdc.gov/foodnet/pub/CID/hardnettf.pdf">http://www.cdc.gov/foodnet/pub/CID/hardnettf.pdf</a>
Hennessy, Thomas W (CDC)	R Marcus, V Deneen, V Reddy, DJ Vugia, J Townes, M Bardsley, D Swerdlow, FJ Angulo, for the Emerging Infections Program (EIP) FoodNet Working Group	Survey of Physician Diagnostic Practices for Patients with Acute Diarrhea: Clinical and Public Health Implications	Clinical Infectious Diseases, 2004;38:S203-S211 <a href="http://www.cdc.gov/foodnet/pub/CID/hennessyt.pdf">http://www.cdc.gov/foodnet/pub/CID/hennessyt.pdf</a>

## Published FoodNet Manuscript

Lead	Co-authors	Title	Citation/Web Link
Hennessy, Thomas W (CDC)	LH Cheng, H Kassenborg, SD Ahuja, J Mohle-Boetani, R Marcus, B Shiferaw, FJ Angulo, for the Emerging Infections Program (EIP) FoodNet Working Group	Egg Consumption is the Principal Risk Factor for Sporadic Salmonella Serotype Heidelberg Infections: A Case-Control Study in FoodNet Sites	Clinical Infectious Diseases, 2004;38:S237-S243 <a href="http://www.cdc.gov/foodnet/pub/CID/hennessyt2.pdf">http://www.cdc.gov/foodnet/pub/CID/hennessyt2.pdf</a>
Imhoff, Beth (CDC)	D Morse, B Shiferaw, MHawkins, D Vugia, S Lance-Parker, J Hadler, C Medus, M Kennedy, MR Moore, T Van Gilder, for the Emerging Infection Program (EIP) FoodNet Working Group	Burden of Self-Reported Acute Diarrheal Illness, United States FoodNet Areas, 1998-1999	Clinical Infectious Diseases, 2004;38:S219-S226 <a href="http://www.cdc.gov/foodnet/pub/CID/imhoffb.pdf">http://www.cdc.gov/foodnet/pub/CID/imhoffb.pdf</a>
Jones, Jeffrey L (CDC)	A Lopez, SP Wahlquist, J Nadle, M Wilson, for the Emerging Infections Program (EIP) FoodNet Working Group	Survey of Clinical Laboratory Practices, Parasitic Diseases	Clinical Infectious Diseases, 2004;38:S198-S202 <a href="http://www.cdc.gov/foodnet/pub/CID/jonesj.pdf">http://www.cdc.gov/foodnet/pub/CID/jonesj.pdf</a>
Jones, Tim F (TN)	B Imhoff, M Samuel, P Mshar, KG McCombs, M Hawkins, V Deneen, M Cambridge, SJ Olsen, for the Emerging Infections Program (EIP) FoodNet Working Group	Limitations to Successful Investigation and Reporting of Foodborne Outbreaks: An Analysis of Foodborne Disease Outbreaks in FoodNet Catchment Areas, 1998-1999	Clinical Infectious Diseases, 2004;38:S297-S302 <a href="http://www.cdc.gov/foodnet/pub/CID/jonest.pdf">http://www.cdc.gov/foodnet/pub/CID/jonest.pdf</a>
Kassenborg, Heidi D (MN)	KE Smith, DJ Vugia, T Rabatsky-Ehr, MR. Bates, MA Carter, NB Dumas, MPCassidy, N Marano, RV Tauxe, FJ Angulo, for the Emerging Infections Program (EIP) FoodNet Working Group	Fluoroquinolone-Resistant Campylobacter Infections: Eating Poultry Outside the Home and Foreign Travel are Risk Factors	Clinical Infectious Diseases, 2004;38:S279-S284 <a href="http://www.cdc.gov/foodnet/pub/CID/kassenborgh.pdf">http://www.cdc.gov/foodnet/pub/CID/kassenborgh.pdf</a>
Kassenborg, Heidi D (MN)	CW Hedberg, M Hoekstra, MC Evans, AE Chin, R Marcus, DJ Vugia, K Smith, SD Ahuja, L Slutsker, PM Griffin, for the Emerging Infections Program (EIP) FoodNet Working Group	Farm Visits and Undercooked Hamburgers as Major Risk Factors for Sporadic Escherichia coli O157:H7 Infection: Data from a Case-Control Study in Five FoodNet Sites	Clinical Infectious Diseases, 2004;38:S271-S278 <a href="http://www.cdc.gov/foodnet/pub/CID/kassenbogh2.pdf">http://www.cdc.gov/foodnet/pub/CID/kassenbogh2.pdf</a>
Kennedy, Malinda (CDC)	R Villar, DJ Vugia, T Rabatsky-Ehr, MM Farley, M Pass, K Smith, P Smith, PR Cieslak, B Imhoff, PM Griffin, for the Emerging Infections Program (EIP) FoodNet Working Group	Hospitalizations and Deaths from Salmonella infections, FoodNet 1996-1999	Clinical Infectious Diseases, 2004;38:S142-S148 <a href="http://www.cdc.gov/foodnet/pub/CID/kennedym.pdf">http://www.cdc.gov/foodnet/pub/CID/kennedym.pdf</a>
Kimura, Akiko C (CA)	V Reddy, R Marcus, PR Cieslak, JC Mohle-Boetani, HD Kassenborg, SD Segler, FP Hardnett, T Barrett, DL Swerdlow, for the Emerging Infections Program (EIP) FoodNet Working Group	Chicken is a Newly Identified Risk Factor for Sporadic Salmonella serotype Enteritidis Infections in the United States: A Case-Control Study in FoodNet Sites	Clinical Infectious Diseases, 2004;38:S244-S252 <a href="http://www.cdc.gov/foodnet/pub/CID/kimuraa.pdf">http://www.cdc.gov/foodnet/pub/CID/kimuraa.pdf</a>
Lee, Robin (CDC)	ME Beatty, AK Bogard, M Esko, FJ Angulo, C Selman, and EHS-Net Working Group	Prevalence of High-Risk Egg-Preparation Practices in Restaurants That Prepare Breakfast Egg Entrees: An EHS-Net Study	Journal of Food Protection, 2004;67(7):1444-50 <a href="http://apt.allenpress.com/aptonline/?request=get-abstract&amp;issn=0362-028X&amp;">http://apt.allenpress.com/aptonline/?request=get-abstract&amp;issn=0362-028X&amp;</a>
Marcus, Ruthanne (CT)	T Rabatsky-Ehr, JC Mohle-Boetani, M Farley, C Medus, B Shiferaw, M Carter, S Zansky, M Kennedy, T Van Gilder, JL Hadler for the Emerging Infections Program (EIP) FoodNet Working Group	Dramatic Decrease in the Incidence of Salmonella Serotype Enteritidis (SE) Infections in Five FoodNet Sites: 1996-1999	Clinical Infectious Diseases, 2004;38:S135-S141 <a href="http://www.cdc.gov/foodnet/pub/CID/marcusr.pdf">http://www.cdc.gov/foodnet/pub/CID/marcusr.pdf</a>

## Published FoodNet Manuscript

Lead	Co-authors	Title	Citation/Web Link
Mermin, Jonathan (CDC)	L Hutwagner, D Vugia, S Shallow, P Daily, J Bender, J Koehler, R Marcus, and F Angulo, for the Emerging Infections Program (EIP) FoodNet Working Group	Reptiles, Amphibians, and Human Salmonella Infection: A Population-Based, Case-Control Study	Clinical Infectious Diseases, 2004;38:S253-S261 <a href="http://www.cdc.gov/foodnet/pub/CID/merminj.pdf">http://www.cdc.gov/foodnet/pub/CID/merminj.pdf</a>
Nelson, Jennifer (CDC)	KE Smith, DJ Vugia, T Rabatsky-Her, S Segler, H Kassenborg, S Zansky, K Joyce, N Marano, M Hoekstra, FJ Angulo	Prolonged duration of diarrhea associated with fluoroquinolone-resistant Campylobacter infections	Journal of Infectious Diseases, 2004;190:1150-7. <a href="http://www.cdc.gov/foodnet/pub/publications/2004/J_nelson_FQRX_Campy">http://www.cdc.gov/foodnet/pub/publications/2004/J_nelson_FQRX_Campy</a>
Ray, Susan M (GA)	SD Ahuja, PA Blake, MM Farley, M Samuel, T Fiorentino, E Swanson, M Cassidy, JC Lay, T Van Gilder, for the Emerging Infections Program (EIP) FoodNet Working Group	Population-Based Surveillance for Yersinia enterocolitica Infection: Higher Risk of Disease in Infants and Minority Populations	Clinical Infectious Diseases, 2004;38:S181-S189 <a href="http://www.journals.uchicago.edu/CID/journal/issues/v38nS3/32112/32112">http://www.journals.uchicago.edu/CID/journal/issues/v38nS3/32112/32112</a> .
Rees, Judy R	MA Davis, A McNeese, S Shallow, FJ Angulo, DJ Vugia	Persistent Diarrhea, Arthritis, and Other Complications of Enteric Infections: A Pilot Survey	Clinical Infectious Diseases, 2004;38:S311-S317 <a href="http://www.cdc.gov/foodnet/pub/CID/reesj.pdf">http://www.cdc.gov/foodnet/pub/CID/reesj.pdf</a>
Rowe, Samantha Y (CDC)	JR Rocourt, B Shiferaw, HD Kassenborg, SD eglar, R Marcus, PJ Daily, FP Hardnett, L Slutsker, for the Emerging Infections Program (EIP) FoodNet Working Group	Breast-Feeding Decreases Risk of Sporadic Salmonellosis Among Infants in FoodNet Sites	Clinical Infectious Diseases, 2004;38:S262-S270 <a href="http://www.cdc.gov/foodnet/pub/CID/rowes.pdf">http://www.cdc.gov/foodnet/pub/CID/rowes.pdf</a>
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Frenzen, Paul (USDA)	A Majchrowicz, B Buzby, B Imhoff, and the FoodNet Working Group	Consumer Acceptance of Irradiated Meat and Poultry Products	Agriculture Information Bulletin, 2000; 757:1-8 <a href="http://www.cdc.gov/foodnet/pub/publications/frenzen_p_2/frenzen_p_2.htm">http://www.cdc.gov/foodnet/pub/publications/frenzen_p_2/frenzen_p_2.htm</a>
Kennedy, Malinda (CDC)	FJ Angulo and the FoodNet Working Group.	Incidence of Foodborne Illnesses: 1999 Data from FoodNet	Irish Journal of Agricultural and Food Research 2000; 39: 295-300 <a href="http://www.cdc.gov/foodnet/pub/publications/kennedy_m/kennedy_m.htm">http://www.cdc.gov/foodnet/pub/publications/kennedy_m/kennedy_m.htm</a>
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Wallace, David J (CDC)	T Van Gilder, S Shallow, T Fiorentino, SD Segler, KE Smith B Shiferaw, R Etzel, WE Garthright, FJ Angulo, and the FoodNet Working Group	Incidence of Foodborne Illnesses Reported by the Foodborne Diseases Active Surveillance Network (FoodNet)-1997.	Journal of Food Protection 2000; 63 (6): 807-809. <a href="http://www.cdc.gov/foodnet/pub/publications/2000/wallace_d.htm">http://www.cdc.gov/foodnet/pub/publications/2000/wallace_d.htm</a>
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Centers for Disease Control and Prevention	FoodNet Working Group	Incidence of Foodborne Illnesses: Preliminary Data from the Foodborne Diseases Active Surveillance Network (FoodNet) - United States, 1998	MMWR 1999; 48 (9): 189-194 <a href="http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00054940.htm">http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00054940.htm</a>
Frenzen, Paul (USDA)	T Riggs, J Buzby, T Breuer, T Roberts, D Voetsch, S Reddy, and the FoodNet Working Group	Salmonella Cost Estimate Update Using FoodNet Data	Food Review 1999; 22 (2): 10-15 <a href="http://www.cdc.gov/foodnet/pub/publications/frenzen_p/frenzen_p.htm">http://www.cdc.gov/foodnet/pub/publications/frenzen_p/frenzen_p.htm</a>
Frenzen, Paul (USDA-ERS))	T Riggs, J Buzby, T Breur, T Roberts, D Voetsch, S Reddy, and the FoodNet Working Group	Salmonella cost estimate update using FoodNet data	Food Review, 1999;22(2):10-15 <a href="http://www.cdc.gov/foodnet/pus/salmo.htm">http://www.cdc.gov/foodnet/pus/salmo.htm</a>
Herikstad, Hallgeir (Denmark)	S Yang, TJ Van Gilder, DJ Vugia, J Hadler, P Blake, V Deneen, B Shiferaw, FJ Angulo FJ, and the FoodNet Working Group	A Population-Based Estimate of the Burden of Diarrheal Illness in the United States: FoodNet, 1996-1997	Epidemiology and Infection 2002; 129:9-17. <a href="http://www.cdc.gov/foodnet/pub/publications/2002/herikstad_h.htm">http://www.cdc.gov/foodnet/pub/publications/2002/herikstad_h.htm</a>

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Angulo, Fred (CDC)	A Voetsch, D Vugia, J Hadle, M Farley, C Hedberg, P Cieslak, D Morse, D Dwyer, D Swerdlow, FoodNet Working group.	Determining the Burden of Human Illness from Foodborne Diseases: CDC's Emerging Infectious Disease Program Foodborne Disease Active Surveillance Network (FoodNet).	Veterinary Clinics of North America: Food Animal Practice 1998; 14: 165-1 <a href="http://www.cdc.gov/foodnet/pub/publications/1998/angulo_f/angulo_f.htm">http://www.cdc.gov/foodnet/pub/publications/1998/angulo_f/angulo_f.htm</a>
Centers for Disease Control and Prevention		Outbreak of Vibrio parahaemolyticus Infections Associated with Eating Raw oysters - pacific Northwest, 1997	MMWR 1998; 47 (22): 457-462 <a href="http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00053377.htm">http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00053377.htm</a>
Centers for Disease Control and Prevention	FoodNet Working Group	Incidence of Foodborne Illnesses- FoodNet 1997	MMWR 1998; 47 (37): 782 <a href="http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00054940.htm">http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00054940.htm</a>
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Centers for Disease Control and Prevention	FoodNet Working Group	Foodborne Diseases Active Surveillance Network 1996.	MMWR 1997; 46 (12): 258-261 <a href="http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00046981.htm">http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00046981.htm</a>
<b>1996</b>			
Centers for Disease Control and Prevention		Surveillance for Creutzfeldt-Jakob Disease - United States	MMWR 1996; 45 (31): 665-668 <a href="http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00043220.htm">http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00043220.htm</a>

**Meeting to discuss the status of FoodNet/University of Minnesota projects**

**September 30, 2004 at 8.30AM-3PM**

**University of Minnesota, 420 Delaware St. SE, Minneapolis, MN**

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**Participants:** Fred Angulo (FoodNet CDC)  
Elaine Scallan (FoodNet CDC)  
Nicole Ishill (FoodNet CDC)  
George Maldonado (Univ. MN)  
Carrie Rigdon (Univ. MN)  
Tim Church (Univ. MN)  
Craig Hedberg (Univ. MN)  
Kristin Holt (FSIS, USDA)  
Jane Harman (FSIS, USDA)

**Agenda**

8.30AM	Welcome and introductions
9AM	Point of processing attribution
11AM	Integration of outbreak and case-control study data
12 PM	<i>Lunch</i>
1PM	Analysis of case-control studies
2PM	Future work plan and deliverables
3PM	Depart for airport

**Texas Emerging Infections Program Site Visit  
Austin, Texas, September 13<sup>th</sup>, 2004**

**Attendees:** Dennis Perrotta, Julie Rawlings, Jeff Taylor, Tom Betts, Linda Gaul, Neil Pascoe, Tamara Baldwin, Mary Ann Peterson, (Texas Department of State Health Services), Brian Smith (Region 11 Harlingen), Miguel Escobedo (Region 9/10 El Paso), Rich Taylor (EISO), Bob Pinner, Fred Angulo, Drew Voetsch, Jennifer Nelson, Chris van Beneden, Tami Hilger Skoff, Steve Waterman (CDC)

**Topics of Discussion:**

1. Administrative issues: The Texas Department of Health is reorganizing into the Texas Department of State Health Services (DSHS). There are 11 FTE positions to be hired that will be dedicated to EIP activities; 7 in the regional sites, 2 in the DSHS laboratory, 1 at DSHS to oversee the EIP activities and grant. This person will be a mid-level epidemiologist to serve as scientific advisor, act as point of contact for CDC, and manage EIP budgets. Currently there are 2 DSHS employees to oversee FoodNet (Linda Gaul) and ABC's (Neil Pascoe) activities centrally.
2. Surveillance: The intent of the new EIP funding was to strengthen and integrate current surveillance activities. To accomplish the goals of active surveillance, Texas EIP will initially focus on seven counties; Five (Cameron, Hidalgo, Starr, Willacy, and Zapata) of the counties are located in the Lower Rio Grande, one (Webb) in the middle Rio Grande, and one (El Paso) in the upper Rio Grande. The population for these areas, according to US census, is approximately 1.95 million persons. There was some discussion to expanding to an urban area that may be comparable to other EIP sites (e.g., Austin or Houston) in the future. FoodNet and ABCs surveillance will be integrated (same surveillance officers will serve both programs).
3. Numerator/denominator: The group discussed two potential sources of bias in the rates. First, persons from Mexico coming to the US to seek medical care may artificially increase the numerator in population-based surveillance. There is some evidence from a 1996 population-based survey that persons in the US would not seek medical care for acute illness across the border in Mexico. Second, undercounting by the US census of permanent foreign born residents may artificially decrease the denominator. The effect of these sources of error would be to increase the incidence. According to the 2000 US census, the top three states for states for illegal residents are California (2.2 million), Texas, (1 million), and New York (0.5 million). Brian Smith, Public Health Region 11 Director, estimated that there were 600,000 people living legally in the region and an additional 300,000 people living illegally. This issue has not been systematically addressed in other EIP sites.
4. Las Cruces/El Paso area: Texas EIP will work closely with New Mexico EIP to conduct active surveillance and determine residency of case-patients. Jennifer Nelson and

Elizabeth Ailes will travel to El Paso, Texas in early December in conjunction with ABCs and New Mexico surveillance officers to implement active surveillance.

5. Laboratory survey: In October and November 2005, Texas will conduct a survey of clinical microbiology laboratories in the catchment areas using the 2000 FoodNet/ABCs survey. The survey will be completed by a University of Texas student by December 2004.
6. Pilot data: In January 2005, Texas EIP will collect and transmit pilot data. During the pilot phase, Texas will evaluate the numerator/denominator issue. Texas is using the NEDSS base system statewide. Once the Foodborne Diseases PAM is developed, Texas EIP will transmit FoodNet data using NEDSS.
7. Isolate management: There is no mandatory forwarding of isolates from clinical laboratories to the state public health laboratory. Providing funding for shipping will be used rather than changing state law. Texas public health laboratory can provide pre-paid mailers
8. Special studies:
  - a. *Listeria monocytogenes*: The unique population living on the US Mexico border may provide the opportunity for interventions to prevent foodborne perinatal listeriosis (e.g. Futura Mamá (Expecting Mother) protocol). Isolate collection is statewide for PulseNet molecular subtyping.
  - b. HUS surveillance: HUS is a reportable condition in Texas. There was interest in conducting active surveillance through pediatric nephrologists.
  - c. Follow-up and case-control studies (e.g., travel and outbreak follow up for *E. coli* O157:H7 and *Salmonella* infections). Local health departments are routinely interviewing cases. DSHS will need to standardize surveillance forms within the sites. Routine interviews could be expanded to case-control studies if control populations are enrolled by CDC.
9. Academic collaboration: Currently a laboratory partnership exists with UTMB for the BIDS surveillance. Undergraduate and graduate student interns from UT-Austin have conducted short term research projects. Preventive medicine residents could conduct research through the EIP.

#### Additional references

1. See map of Texas Public Health Regions: <http://www.tdh.state.tx.us/brlho/regions.htm>
2. Survey Health and Environmental Conditions in Texas Border Counties and Colonias: [http://www.epa.gov/orsearth/pdf/exsumrev\\_hetbcc.pdf](http://www.epa.gov/orsearth/pdf/exsumrev_hetbcc.pdf)

## **Agenda**

### Meeting Objectives:

- Exchange information between Texas DSHS and CDC in relation to establishing an EIP in Texas.
- Come to agreement about program and geographic scope for first activities in Texas EIP.
- Define next steps and timelines.

8:30 Welcome and Introductions – Dennis Perrotta

8:45 Emerging Infections Programs Overview and Vision – Bob Pinner

9:00 Texas EIP Plans and Priorities [presentations and discussion]—

- Overview and Current Status of the Texas EIP– Dennis Perrotta
- Geographic Scope
- Program Scope
- Texas EIP Collaborations

10:30 Building Infrastructure and Methods for Population-Based EIP Work in Texas

- Numerators
- Denominators

12:00 Lunch

1:00 Breakouts with Relevant CDC and Texas EIP staff:

- ABCs
- FoodNet/foodborne diseases
- BIDS and Syndrome-based activities

2:30 Implementing and Coordinating Texas EIP Activities:

- Breakout group reports
- Coordinating TX EIP Activities

3:00 Break (Bob leaves for the airport)

3:30 Additional time for Breakout Sessions, if needed.

## Data Confidentiality Provisions

The data will be collected by an independent consulting firm under terms of its contract. The identifiable information about institutions will be kept confidential in accordance with 42 U.S.C. 299c-3(c). AHRQ and HRSA will receive only state-level summary data, and not individual hospital responses.

## Method of Collection

The 2004 preparedness questionnaire will be administered electronically to each hospital via electronic mail. The estimated annual burden is as follows:

### ESTIMATED ANNUAL RESPONDENT BURDEN

Number of questionnaire recipients	Estimated burden/ respondent (minutes)	Total hours of burden
6000 .....	60	6000

The estimate burden is based on the completion of a paper version of the questionnaire by a pilot hospital. The more efficient data collection effort enabled by the electronic format has been taken into account in this estimate. The annualized cost to all potential respondents is estimated at \$209,040 Total (\$34.84/hr [average staff time] × 1 hr. 6000 respondents). Percentage of capital costs, operating costs or maintenance costs are negligible. We propose a census information collection approach as appropriate data on which to develop a stratified, purposive sample is unavailable. Future studies will utilize statistical methods based on our baseline data to develop a sampling scheme.

## Request for Comments

In accordance with the above cited Paperwork Reduction Act legislation, comments on the AHRQ's and HRSA's information collection are requested with regard to any of the following: (a) Whether the proposed collection of information is necessary for the proper performance of functions of AHRQ and HRSA, including whether the information will have practical utility; (b) the accuracy of the agency's estimate of the burden (including hours and costs) of the proposed collection of information (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including the use of automated collection techniques or other forms of information technology.

Comments submitted in response to this notice will be summarized and included in the request for OMB approval of the proposed information collection. All comments will become a matter of public record.

Dated: September 17, 2004.

**Carolyn M. Clancy,**

*Director.*

[FR Doc. 04-21469 Filed 9-23-04; 8:45 am]

**BILLING CODE 4160-90-M**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Disease Control and Prevention

#### Emerging Infections Programs

*Announcement Type:* Competing Continuation.

*Funding Opportunity Number:* CI05-026.

*Catalog of Federal Domestic*

*Assistance Number:* 93.283.

*Key Dates:*

*Letter of Intent Deadline:* October 11, 2004.

*Application Deadline:* November 1, 2004.

*Executive Summary:* The purpose of this program announcement is to provide continued support to existing Emerging Infections Programs (EIPs), or to develop new EIPs, as part of the national network. EIPs are population-based centers which assess the public health impact of and respond to emerging infections. Activities of the EIPs fall into these general categories: (1) Active surveillance; (2) applied public health epidemiologic and laboratory activities; and (3) implementation and evaluation of pilot prevention/intervention projects. The EIPs function as a collaborative network of public and private organizations that have an interest in addressing infectious diseases health issues; EIPs maintain sufficient flexibility to address infectious disease health issues as they emerge. EIPs are strategically located to serve a variety of geographical areas and diverse groups of people.

The following guiding principles motivate the work of the EIPs: (1) EIPs aim to be a national resource for surveillance, prevention, and control of emerging infectious diseases—EIP functions go beyond the routine functions of health departments in ways that allow important public health questions to be answered; (2) EIP activities address important issues in infectious diseases, selected with regard to what is appropriate for this population-based infrastructure; (3) EIPs

maintain sufficient flexibility for emergency response and to address new problems as they arise; (4) training is a key function of the EIPs; (5) EIPs develop and evaluate public health practices and transfer what is learned to the public health community; and (6) EIPs give high priority to activities that lead directly to prevention of disease.

## I. Funding Opportunity Description

**Authority:** This program is authorized under the Public Health Service Act Sections 301(a)[42 U.S.C. 241(a)], 317(k)(1)[42 U.S.C. 247b(k)(1)], and 317(k)(2)[42 U.S.C. 247b(k)(2)], as amended.

**Purpose:** The purpose of the program is to assist in local, state, and national efforts to conduct surveillance and public health epidemiologic and laboratory activities in emerging infectious diseases, and to pilot and evaluate methods for the prevention and control of emerging infectious diseases. This program addresses the "Healthy People 2010" focus area(s) of Immunization and Infectious Diseases.

Measurable outcomes of the program will be in alignment with the following performance goal for the National Center for Infectious Diseases (NCID): Protect Americans from infectious diseases.

**Research Objectives:** The overall objective of the EIP cooperative agreement is to assess the public health impact of and respond to emerging infections. Activities of the EIPs fall into these general categories: (1) Active surveillance; (2) applied public health epidemiologic and laboratory activities; and (3) implementation and evaluation of pilot prevention/intervention projects. Specific objectives for research and other activities supported by this cooperative agreement are outlined in the individual Activities, below.

**Activities:** Awardee activities for this program are as follows:

(a) Functions and structure for EIP—Establish and operate an EIP to further local, State, and national efforts to address emerging infectious diseases.

(1) Establish each EIP activity in a defined population, which could include either an entire State or a geographically defined area (or areas) within a State. The population base may vary for various activities. For certain activities, the population base may be defined by a healthcare delivery system such as a health maintenance organization (HMO). To accomplish the objectives of certain EIP activities, a minimum population base of approximately 1,500,000 may be necessary.

(2) Provide effective scientific leadership, coordination, and execution of EIP activities.

(3) Provide effective management to support operation of the EIP.

(4) Organize the EIP so that it maintains the flexibility to respond to new health problems as they emerge.

(5) Operate the EIP so that it can function effectively as part of a national network of EIPs. Collaborate with CDC and other EIPs, through the EIP steering group and other EIP working groups, to establish priorities, to coordinate and monitor projects, and to assure that important emerging infections issues are appropriately addressed.

(6) Ensure that site representatives attend and participate in EIP Steering Group Meetings and other required EIP meetings.

(7) As a part of certain EIP projects, provide specimens such as disease-causing isolates or serum specimens to appropriate organizations (which may include, but is not limited to CDC) for laboratory evaluation (*e.g.*, molecular epidemiologic studies, evaluation of diagnostic tools).

(8) Manage, analyze, and interpret data from EIP projects; publish and disseminate important public health information stemming from EIP projects in collaboration with CDC and other EIP sites.

(9) Monitor and evaluate scientific and operational accomplishments and progress in achieving the purpose of this program.

(10) If a proposed project involves research on human participants, ensure appropriate IRB review.

(11) Information systems used or developed through this cooperative agreement should conform to the Public Health Information Network (PHIN) standards, the goal of which is the creation of standards-based, interoperable public health information systems. For more information on PHIN, the PHIN architecture, PHIN messaging, and PHIN standards, functions, and specifications, see the CDC Web site: <http://www.cdc.gov/phn>. CDC will work with EIP sites to evolve EIP information systems to conform to PHIN standards.

(b) Partnerships—Develop the EIP as a partnership between the health department and other public and private organizations that have an interest in addressing public health issues relating to emerging infectious diseases, *e.g.*, local public health agencies, academic institutions, health care providers, infection control professionals, clinical laboratories, other Federal and state government agencies, and research organizations. Build and draw upon

these relationships for the conduct of specific EIP activities.

(c) Tools and Capacities—Develop and utilize a set of tools or capacities to conduct EIP activities, *e.g.*, active laboratory-based surveillance; medical records review for surveillance or studies; case-control studies; selected laboratory testing of isolates or specimens; surveys (*e.g.*, of laboratories, providers, public); collection of isolates of disease-causing agents in the context of surveillance; network of infection control professionals; and analyses of hospital admission or discharge data.

(d) General EIP Activities—Activities of the EIPs generally fall into three categories:

(1) Active population-based surveillance projects. These may include collection and submission of disease-causing infectious agents to state, CDC, or other laboratories. For example, the surveillance case definition for the condition might involve detection of a positive culture or a drug resistant isolate in a microbiology laboratory, a serologic test result, a histopathologic finding, or a clinical syndrome, depending upon the disease or condition under surveillance. The specific approach to surveillance could also vary depending on the disease or condition under surveillance. Surveillance should be comprehensive (*e.g.*, may include audits to assure complete reporting) with active case-finding.

(2) Applied epidemiologic and applied laboratory projects. Examples of potential projects include: Evaluation of illnesses often not specifically diagnosed for which information about trends and etiology are important (*e.g.*, pneumonia); evaluation of clinical outcomes or risk factors for drug resistant infections; evaluation of the role of human genomics in disease causation and individual susceptibility; and evaluation of the efficacy of pneumococcal and meningococcal conjugate vaccines.

(3) Implementation and evaluation of pilot prevention/intervention projects for emerging infectious diseases. Examples might include, *e.g.*, evaluation of the impact of Group B Streptococcus prevention guidelines, or evaluation of the role of human genomics in public health investigations.

(e) Specific EIP activities—All applicants should propose activities #1–5; additional activities may be proposed (#6–12) at the discretion of the applicant. Each application will be evaluated as a whole (see Criteria for evaluation in Section V.1 below). Therefore, any additional activity proposals should be commensurate with

the applicant's capacity and should be designed to enhance the applications as whole. Applicants are invited to consult with CDC programs in planning their proposed activities. [For details about these activities, see Appendices posted on the CDC Web site: <http://www.cdc.gov/od/pgo/funding/grantmain.htm>.]

(1) Active Bacterial Core surveillance (ABCs) and related activities—ALL applicants should propose this activity. CDC expects to provide support for ABCs activities in all EIPs, although some ABCs activities are expected to be conducted only in certain sites. For more details, see Appendix 1 posted on the CDC Web site: <http://www.cdc.gov/od/pgo/funding/grantmain.htm>.

(2) Active population-based laboratory surveillance for food-borne diseases (FoodNet) and related activities—ALL applicants should propose this activity. CDC expects to provide support for FoodNet activities in all EIPs, although some FoodNet activities are expected to be conducted only in certain sites. For more details, see Appendix 2 posted on the CDC Web site: <http://www.cdc.gov/od/pgo/funding/grantmain.htm>.

(3) Surveillance for respiratory diseases and syndromes—ALL applicants should propose this activity. CDC expects to provide support for five to nine EIPs for one or more aspects of this activity. For more detailed guidance, see Appendix 3 posted on the CDC Web site: <http://www.cdc.gov/od/pgo/funding/grantmain.htm>.

(4) Flexible Response to Emerging Problems—ALL applicants should propose this activity. Each EIP will be expected to participate in a workgroup to review newly emerging infectious disease issues on short notice and contribute to rapid study design, initiation, and completion. For more details, see Appendix 4 posted on the CDC Web site: <http://www.cdc.gov/od/pgo/funding/grantmain.htm>.

(5) EIP rapid population-based survey capacity—ALL applicants should propose this activity. CDC expects to provide support for population-based survey capacity in all EIP sites. For detailed guidance on applying for this activity, see Appendix 5 posted on the CDC Web site: <http://www.cdc.gov/od/pgo/funding/grantmain.htm>.

(6) Integrated hepatitis surveillance—Applicants may choose to propose some or all components of this activity, and CDC may provide some support for each of the components. For detailed guidance and specific eligibility criteria for this activity, see Appendix 6 posted on the CDC Web site: <http://www.cdc.gov/od/pgo/funding/grantmain.htm>.

[www.cdc.gov/od/pgo/funding/grantmain.htm](http://www.cdc.gov/od/pgo/funding/grantmain.htm).

(7) Surveillance for encephalitis syndrome—Applicants may choose to propose this activity. CDC expects to provide support for up to three EIPs for this activity. For more details, see Appendix 7 posted on the CDC Web site: <http://www.cdc.gov/od/pgo/funding/grantmain.htm>.

(8) Surveillance for Unexplained Deaths (UNEX)—EIPs that are currently conducting UNEX may choose to propose to continue this activity. Any proposal for syndrome surveillance, e.g., respiratory syndromes, should be proposed and managed as part of the corresponding EIP syndrome activity, not separately as part of this activity. For more details, see Appendix 7 posted on the CDC Web site: <http://www.cdc.gov/od/pgo/funding/grantmain.htm>.

(9) Border Infectious Disease Surveillance (BIDS)—Applicants along the U.S./Mexico Border may propose this activity. For more details, see Appendix 7 posted on the CDC Web site: <http://www.cdc.gov/od/pgo/funding/grantmain.htm>.

(10) Incorporate a training activity into the operation of the EIP—Any applicant may propose this activity. See Appendix 7 for details.

(11) Prepare for and engage in activities to assess human genomics risk factors into acute public health investigations—Any applicant may propose this activity. CDC may provide support for one to three sites for this activity. For more details, see Appendix 7 posted on the CDC Web site: <http://www.cdc.gov/od/pgo/funding/grantmain.htm>.

(12) Site-specific EIP activity—Applicants may propose other activities of local interest or concern that are consistent with EIP objectives and guiding principles.

In a cooperative agreement, CDC staff is substantially involved in the program activities, above and beyond routine grant monitoring.

CDC Activities for this program are as follows:

- (a) Provide general coordination for the EIPs as a network.
- (b) Assist in developing collaborative relationships and facilitate multi-site collaboration as needed to support the successful completion of the project.
- (c) Provide consultation, scientific and technical assistance in the operation of the EIP and in designing and conducting individual EIP projects. (Examples include, participating in protocol development, helping with study design, assisting in the development of information systems,

data analysis and dissemination of results, coordinating and facilitating communications among EIPs).

(d) Participate in analysis and interpretation of data from EIP projects. Participate in the dissemination of findings and information stemming from EIP projects.

(e) Assist in monitoring and evaluating scientific and operational accomplishments of the EIP and progress in achieving the purpose and overall goals of this program.

(f) If needed, perform laboratory evaluation of specimens or isolates (e.g., molecular epidemiologic studies, evaluation of diagnostic tools) obtained in EIP projects and integrate results with other data from EIP projects.

(g) If a proposed project involves research with human subjects and CDC scientists will be co-investigators in that research, assist in the development of a research protocol for IRB review by all institutions participating in the research project. The CDC IRB will review and approve the project initially and on, at least, an annual basis until the research project is completed.

(h) Consult with sites to assist evolution of EIP-related information systems to conform to Public Health Information Network (PHIN) standards.

## II. Award Information

*Type of Award:* Cooperative Agreement. CDC involvement in this program is listed in the Activities Section above.

*Mechanism of Support:* U01.

*Fiscal Year Funds:* 2005.

*Approximate Total Funding:* \$19,600,000.

*Approximate Number of Awards:* 9.

*Approximate Average Award:* \$2,400,000. (This amount is for the first 12-month budget period, and includes both direct and indirect costs.)

*Floor of Award Range:* \$1,400,000.

*Ceiling of Award Range:* \$3,500,000.

*Anticipated Award Date:* December 29, 2004.

*Budget Period Length:* 12 months.

*Project Period Length:* 5 years.

Throughout the project period, CDC's commitment to continuation of awards will be conditioned on the availability of funds, evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the Federal Government.

## III. Eligibility Information

### III.1. Eligible Applicants

Applications may be submitted by state governments or their Bona Fide

Agents (this includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau).

A Bona Fide Agent is an agency/organization identified by the state as eligible to submit an application under the state eligibility in lieu of a state application. If you are applying as a bona fide agent of a state or local government, you must provide a letter from the state or local government as documentation of your status. Place this documentation behind the first page of your application form.

### III.2. Cost Sharing or Matching

Matching funds are not required for this program.

### III.3. Other

CDC will accept and review applications with budgets greater than the ceiling of the award range.

### Special Requirements

If your application is incomplete or non-responsive to the requirements listed in this section, it will not be entered into the review process. You will be notified that your application did not meet submission requirements.

- Late applications will be considered non-responsive. See "Section IV.3. Submission Dates and Times" for more information on deadlines.

- **Note:** Title 2 of the United States Code section 1611 states that an organization described in section 501(c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible to receive Federal funds constituting an award, grant, or loan.

Individuals Eligible To Become Principal Investigators or Co-Principal Investigators

Any individual with the skills, knowledge, and resources necessary to carry out the proposed EIP activities is invited to work with their institution to develop an application for support. Individuals from underrepresented racial and ethnic groups as well as individuals with disabilities are always encouraged to apply for CDC programs.

## IV. Application and Submission Information

### IV.1. Address To Request Application Package

To apply for this funding opportunity use application form PHS 398 (OMB number 0925-0001 rev. 5/2001). Forms and instructions are available in an

interactive format on the CDC Web site, at the following Internet address: <http://www.cdc.gov/od/pgo/forminfo.htm>.

Forms and instructions are also available in an interactive format on the National Institutes of Health (NIH) Web site, at the following Internet address: <http://grants.nih.gov/grants/funding/phs398/phs398.html>.

If you do not have access to the Internet, or if you have difficulty accessing the forms on-line, you may contact the CDC Procurement and Grants Office Technical Information Management Section (PGO-TIM) staff at: (770) 488-2700. Application forms can be mailed to you.

#### IV.2. Content and Form of Submission

##### Letter of Intent (LOI)

A letter of intent is requested to help plan the application review, but it is not mandatory. Your LOI must be written in the following format:

- Maximum number of pages: 2.
- Font size: 12-point un-reduced.
- Single spaced.
- Paper size: 8.5 by 11 inches.
- Page margin size: One inch.
- Printed only on one side of page.
- Written in plain language, avoid jargon.

Your LOI must include the following information:

- Number and title of this Program Announcement (PA).
- Name of Applicant (*i.e.* State Health Department or *bona fide* agent).

If you are applying as a *bona fide* agent of a state or local government, you must provide a letter from the state as documentation of your status at the time of application.

- Name, address, e-mail address, and telephone number of the Principal Investigator and Co-Investigator.
- Brief description of your eligibility and intent to apply.

##### Application

Follow the PHS 398 application instructions for content and formatting of your application. If the instructions in this announcement differ in any way from the PHS 398 instructions, follow the instructions in this announcement. For further assistance with the PHS 398 application form, contact PGO-TIM staff at (770) 488-2700, or contact GrantsInfo, Telephone (301) 435-0714, e-mail: [GrantsInfo@nih.gov](mailto:GrantsInfo@nih.gov).

Your research plan should address activities to be conducted over the entire project period, focusing in detail on the first year and summarizing plans for subsequent years.

You are required to have a Dun and Bradstreet Data Universal Numbering

System (DUNS) number to apply for a grant or cooperative agreement from the Federal government. Your DUNS number must be entered on line 11 of the face page of the PHS 398 application form. The DUNS number is a nine-digit identification number, which uniquely identifies business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access <http://www.dunandbradstreet.com> or call 1-866-705-5711.

For more information, see the CDC Web site at: <http://www.cdc.gov/od/pgo/funding/pubcommnt.htm>.

This announcement uses just-in-time concepts.

This announcement uses the non-modular budgeting format.

In place of the format specified for the Research Plan in PHS Form 398, use the following format:

- Maximum number of pages: 35 single-spaced (excluding budget, budget narrative, appendices, and required forms).

If your narrative exceeds the page limit, only the first pages which are within the page limit will be reviewed. Materials or information that should be included in the narrative will not be reviewed if placed in the appendices.

- Font size: 12 point un-reduced.
- Paper size: 8.5 by 11 inches.
- Page margin size: One inch.
- Printed only on one side of page.
- Held together only by rubber bands or metal clips; not bound in any other way.

Your narrative should address activities to be conducted over the entire project period, and must include the following items in the order listed:

- (1) Capacity to carry out the functions and responsibilities of an EIP.
- (2) Operational plan for the EIP in general and for specific EIP activities. (Include descriptions of populations for each proposed activity.)
- (3) Measures of Effectiveness (Include Measures for each of the specific EIP activities proposed.)
- (4) Human Subjects.

Additional information may be included in the application appendices. The appendices will not be counted toward the narrative page limit. This additional information includes:

- Documentation of *bona fide* agent status.
- Letters of support (Do not solicit or include letters of support from CDC personnel.)
- *Curricula vitas*.
- Detailed budget justification (*i.e.*, supporting budget information outlined in "Budget and Budget Narrative" below.)

- Documentation of relevant accomplishments, such as abstracts, manuscripts, or bibliographies, may be included in appendices.

##### Budget and Budget Narrative

This part of the application does not count toward the narrative page limit. For each line-item (as identified on the PHS Form 398, Page 4), show both Federal and non-Federal (*e.g.*, State funding) shares of total cost for the EIP. For each staff member listed under the Personnel line item, indicate their specific responsibilities relative to each of the proposed projects. All other line-items should also be clearly justified. In addition to the budget justification, provide an estimate of the budget for each separate activity or project (*e.g.*, FoodNet, ABCs, etc. as outlined above in Section I, Activities, section (e)). If requesting funds for any contracts, provide the following information for each proposed contract: (1) Name of proposed contractor; (2) breakdown and justification for estimated costs; (3) description and scope of activities to be performed by contractor; (4) period of performance; and (5) method of contractor selection (*e.g.* sole-source or competitive solicitation).

Additional requirements that may require you to submit additional documentation with your application are listed in section "VI.2. Administrative and National Policy Requirements."

#### IV.3. Submission Dates and Times

##### LOI Deadline Date

October 11, 2004.

CDC requests that you send a LOI if you intend to apply for this program. Although the LOI is not required, not binding, and does not enter into the review of your subsequent application, the LOI will be used to gauge the level of interest in this program, and to allow CDC to plan the application review.

##### Application Deadline Date

November 1, 2004.

##### Explanation of Deadlines

**Applications must be received in the CDC Procurement and Grants Office by 4 p.m. eastern standard time on the deadline date.** If you send your application by the United States Postal Service or commercial delivery service, you must ensure that the carrier will be able to guarantee delivery of the application by the closing date and time. If CDC receives your application after closing due to: (1) Carrier error, when the carrier accepted the package with a guarantee for delivery by the closing date and time, or (2) significant

weather delays or natural disasters, you will be given the opportunity to submit documentation of the carrier's guarantee. If the documentation verifies a carrier problem, CDC will consider the application as having been received by the deadline.

This announcement is the definitive guide on application submission address and deadline. It supersedes information provided in the application instructions. If your application does not meet the deadline above, it will not be eligible for review, and will be discarded. You will be notified that your application did not meet the submission requirements.

CDC will not notify you upon receipt of your application. If you have a question about the receipt of your application, first contact your courier. If you still have a question, contact the PGO-TIM staff at: (770) 488-2700. Before calling, please wait two to three days after the application deadline. This will allow time for applications to be processed and logged.

#### *IV.4. Intergovernmental Review of Applications*

Your application is subject to Intergovernmental Review of Federal Programs, as governed by Executive Order (EO) 12372. This order sets up a system for state and local governmental review of proposed federal assistance applications. You should contact your state single point of contact (SPOC) as early as possible to alert the SPOC to prospective applications, and to receive instructions on your state's process. Click on the following link to get the current SPOC list: <http://www.whitehouse.gov/omb/grants/spoc.html>.

#### *IV.5. Funding Restrictions*

Restrictions, which must be taken into account while writing your budget, are as follows:

- Funds relating to the conduct of research will not be released until the appropriate assurances and Institutional Review Board approvals are in place.
- Continuation awards within an approved project period will be made on the basis of satisfactory progress as evidenced by required reports and the availability of funds.

If you are requesting indirect costs in your budget, you must include a copy of your indirect cost rate agreement. If your indirect cost rate is a provisional rate, the agreement should be less than 12 months of age.

#### *IV.6. Other Submission Requirements*

##### *LOI Submission Address*

Submit your LOI by express mail, delivery service, fax, or e-mail to: Angela Slaughter, National Center for Infectious Diseases (NCID), Centers for Disease Control and Prevention (CDC), 1600 Clifton Rd, NE., Mailstop D-59, Atlanta, GA 30333, Telephone: (404) 371-5357, e-mail address: [aslaughter@cdc.gov](mailto:aslaughter@cdc.gov).

##### *Application Submission Address*

Submit the original and four hard copies of your application by mail or express delivery service to: Technical Information Management—CI05-026, CDC Procurement and Grants Office, 2920 Brandywine Road, Atlanta, GA 30341.

Applications may not be submitted electronically at this time.

#### **V. Application Review Information**

##### *V.1. Criteria*

Applicants are required to provide measures of effectiveness that will demonstrate the accomplishment of the various identified objectives of the cooperative agreement. Measures of effectiveness must relate to the performance goals stated in the "Purpose" section of this announcement. Measures must be objective and quantitative, and must measure the intended outcome. These measures of effectiveness must be submitted with the application and will be an element of evaluation.

The goals of CDC-supported research are to advance the understanding of biological systems, improve the control and prevention of disease and injury, and enhance health. In the written comments, reviewers will be asked to evaluate the application in order to judge the likelihood that the proposed research will have a substantial impact on the pursuit of these goals.

Your application will be evaluated against the following criteria:

- (1) Capacity to carry out the functions and responsibilities of an EIP. (50 points)
  - (a) Does the applicant demonstrate a clear understanding of the objectives of the EIP in the following aspects?
    - (i) Background and objectives of this cooperative agreement program.
    - (ii) The roles and responsibilities of participation in the EIP network.
    - (iii) The requirements, responsibilities, problems, constraints, and complexities that may be encountered in establishing and operating the EIP.
    - (b) EIP functions and structure.

(i) To what extent does the applicant's plan for establishing and operating the EIP clearly describe the proposed organizational and operating structure/procedures; and clearly identify the roles and responsibilities of all participating agencies, organizations, institutions, and individuals?

(ii) To what extent does the applicant describe how the EIP as a whole will be established in a defined population with a minimum population base of approximately 1,500,000 persons?

(iii) To what extent does the applicant clearly describe how the EIP, or its design for the EIP, is flexible and able to swiftly address new public health challenges in infectious diseases?

(iv) Does the applicant plan to provide effective scientific leadership and coordination, and adequate administrative infrastructure, to manage an EIP?

(v) Does the applicant demonstrate ability to operate the EIP so it can function effectively as part of a national network of EIPs?

(vi) To what extent does the applicant describe plans for collaboration with CDC and other EIP sites in the establishment and operation of the EIP and individual EIP projects, including project design/development (e.g., protocols), management and analysis of data, and synthesis and dissemination of findings?

##### *(c) Partnerships.*

(i) To what extent does the applicant demonstrate ability to develop and maintain strong cooperative relationships with public and private, local and regional, medical, public health, laboratory, academic, and community organizations? Does the applicant provide sufficient evidence of its ability to solicit and secure programmatic collaboration and support from such organizations?

(ii) Are the applicant's partnerships with necessary and appropriate organizations adequate for establishing and operating the proposed EIP and for conducting individual EIP projects?

##### *(d) EIP tools and capacities.*

To what extent does the applicant demonstrate past experience and documentation of accomplishments in conducting active surveillance, applied epidemiologic research, applied laboratory research, and prevention research, in general, and on emerging infectious diseases, including antimicrobial resistant, food-borne and waterborne, and currently or potentially vaccine preventable diseases? Is a list of relevant papers and abstracts included in an appendix?

(2) Operational Plan for the EIP in general and for specific EIP activities. (40 points)

(a) General EIP Activities:

(i) To what extent is the quality of the proposed projects (as requested in the Application Content section above), taken as a whole, consistent with EIP guiding principles, public health needs, intent of this program, feasibility, methodology/approach, and collaboration/participation of partner organizations? Does the proposal include clear descriptions of the population bases for each project, and include descriptions of race and ethnic distributions and descriptions of various special populations as they relate to the proposed activities, such as the rural or inner-city poor, under-served women and children, the homeless, immigrants and refugees, and persons infected with HIV?

(ii) Does the applicant demonstrate support from non-applicant participating agencies, institutions, organizations, laboratories, individuals, and consultants included in the operational plan? Does the applicant provide (in an appendix) letters of support which clearly indicate collaborators' commitment to participate in the EIP and define their roles?

(iii) Does the applicant clearly identify key professional personnel to be assigned to the EIP and EIP projects as well as key professional personnel from other participating or collaborating institutions, agencies, and organizations outside of the applicant's agency that will be assigned to EIP activities? (Is curriculum vitae for each person included in an appendix?) Is there a clear identification of participants' respective roles in the management and operation of the EIP? Do participants have adequate experience in conducting work comparable to that described in this announcement?

(iv) For projects involving human subjects research, does the application adequately address the CDC Policy requirements regarding the inclusion of women, ethnic, and racial groups in the proposed research? This includes: (1) The proposed plan for the inclusion of both sexes and racial and ethnic minority populations for appropriate representation; (2) The proposed justification when representation is limited or absent; (3) A statement as to whether the design of the study is adequate to measure differences when warranted; and (4) A statement as to whether the plans for recruitment and outreach for study participants include the process of establishing partnerships

with community(ies) and recognition of mutual benefits.

(b) Specific EIP Activities:

(i) What is the quality of each proposed project with respect to planned approach and methodology, as well as consistency with EIP guiding principles, public health needs, intent of this program, and collaborations?

(ii) For each proposed activity, is there a clear definition of the geographic area and population base in which the activity will operate (different activities may use different populations)?

(iii) For each proposed activity, is there evidence of support from non-applicant participating agencies, institutions, organizations, laboratories, individuals, consultants, etc., included in the operational plan? Does the applicant provide (in an appendix) letters of support which clearly indicate collaborators' commitment to participate in the EIP and define their roles?

(iv) For each proposed activity, does the applicant clearly identify key professional personnel to be assigned to the EIP and EIP projects as well as key professional personnel from other participating or collaborating institutions, agencies, and organizations outside of the applicant's agency that will be assigned to EIP activities (provide a curriculum vitae for each in an appendix). Clear identification of participants' respective roles in the management and operation of the EIP? Do participants have adequate experience in conducting work comparable to that proposed in this announcement?

(3) Measures of Effectiveness (10 points)

(a) Does the applicant provide measures of effectiveness for each proposed activity that will demonstrate the accomplishment of the cooperative agreement objectives identified in Section B "Purpose" of this program announcement?

(b) Are the measures objective and quantitative, and do they adequately measure the intended outcome of each activity?

(4) Budget (not scored)

Is the line-item budget detail broken out for each activity (or project) and contract, clearly justified, and consistent with the purpose and objectives of this program? Does the applicant show both Federal and non-Federal (e.g., State funding) shares of total cost for the EIP?

(5) Human Subjects (not scored)

Does the application adequately address the requirements of Title 45 CFR Part 46 for the protection of human subjects? (Not scored; however, an application can be disapproved if the

research risks are sufficiently serious and protection against risks is so inadequate as to make the entire application unacceptable.)

V.2. Review and Selection Process

Applications will be reviewed for completeness by the Procurement and Grants Office (PGO) staff, and for responsiveness by National Centers for Infectious Diseases (NCID) Office of Surveillance. Incomplete applications and applications that are non-responsive to the eligibility criteria will not advance through the review process.

Applicants will be notified that their application did not meet submission requirements.

An objective review panel will evaluate complete and responsive applications against the evaluation criteria. In addition, the following factors may affect the funding decision:

- Funding preference may be given to approved applications that would enhance the geographic diversity of the network to achieve appropriate geographic representation in the EIPs.
- Funding preference may also be given to competing continuation applications over applications for programs not already receiving support under this cooperative agreement.

VI. Award Administration Information

VI.1. Award Notices

Successful applicants will receive a Notice of Grant Award (NGA) from the CDC Procurement and Grants Office. The NGA shall be the only binding, authorizing document between the recipient and CDC. The NGA will be signed by an authorized Grants Management Officer, and mailed to the recipient fiscal officer identified in the application.

Unsuccessful applicants will receive notification of the results of the application review by mail.

VI.2. Administrative and National Policy Requirements

45 CFR Part 74 and Part 92

For more information on the Code of Federal Regulations, see the National Archives and Records Administration at the following Internet address: <http://www.access.gpo.gov/nara/cfr/cfr-table-search.html>.

The following additional requirements apply to this project:

- AR-1 Human Subjects Requirements
- AR-2 Requirements for Inclusion of Women and Racial and Ethnic Minorities in Research
- AR-7 Executive Order 12372

- AR-9 Paperwork Reduction Act Requirements
- AR-10 Smoke-Free Workplace Requirements

- AR-11 Healthy People 2010
- AR-12 Lobbying Restrictions
- AR-22 Research Integrity

Additional information on these requirements can be found on the CDC Web site at the following Internet address: <http://www.cdc.gov/od/pgo/funding/ARs.htm>.

### VI.3. Reporting Requirements

You must provide CDC with an original, plus two hard copies of the following reports:

(1) Interim progress report, (use form PHS 2590, OMB Number 0925-0001, rev. 5/2001 as posted on the CDC Web site) no less than 90 days before the end of the budget period. The progress report will serve as your non-competing continuation application, and must contain the following elements:

(a) Current Budget Period Activities Objectives including report specifically on progress towards stated Measures of Effectiveness from the current budget period (*i.e.*, previous application).

(b) Current Budget Period Financial Progress.

(c) New Budget Period Program Proposed Activity and Objectives.

(d) Budget.

(e) Measures of Effectiveness.

(f) Additional Requested Information

(2) Financial status report and annual progress report, no more than 90 days after the end of the budget period.

(3) Final financial and performance reports, no more than 90 days after the end of the project period.

These reports must be mailed to the Grants Management or Contract Specialist listed in the "Agency Contacts" section of this announcement.

### VII. Agency Contacts

For general questions about this announcement, contact: Technical Information Management Section, CDC Procurement and Grants Office, 2920 Brandywine Road, Atlanta, GA 30341, Telephone: (770) 488-2700.

For program technical assistance, contact: Catherine Rebmann, National Center for Infectious Diseases (NCID), Centers for Disease Control and Prevention (CDC), 1600 Clifton Rd, NE., Mailstop D-59, Atlanta, GA 30333, Telephone (404) 371-5363, e-mail address: [csr9@cdc.gov](mailto:csr9@cdc.gov).

For financial, grants management, or budget assistance, contact: Lynn Walling, Grants Management Specialist, CDC Procurement and Grants Office, 2920 Brandywine Road, Atlanta, GA 30341, Telephone: (770) 488-2612, e-mail: [lqw5@cdc.gov](mailto:lqw5@cdc.gov).

### VIII. Other Information

This and other CDC funding opportunity announcement can be found on the CDC Web site, Internet address: <http://www.cdc.gov>. Click on "Funding" then "Grants and Cooperative Agreements."

Visit these websites for additional information about the EIPs:

<http://www.cdc.gov/ncidod/EID/vol9no7/03-0083.htm>,  
<http://www.cdc.gov/ncidod/osr/site/eip/index.htm>,  
<http://www.cdc.gov/ncidod/osr/site/eip/publications.htm>.

Dated: September 20, 2004.

**William P. Nichols,**

*Acting Director, Procurement and Grants Office, Centers for Disease Control and Prevention.*

[FR Doc. 04-21474 Filed 9-23-04; 8:45 am]

**BILLING CODE 4163-18-P**

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### Centers for Medicare & Medicaid Services

[CMS-3154-N]

#### Medicare Program; Request for Nominations for Members for the Medicare Coverage Advisory Committee

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.

**ACTION:** Notice.

**SUMMARY:** This notice requests nominations for consideration for membership on the Medicare Coverage Advisory Committee (MCAC).

**DATES:** Nominations will be considered if received at the designated address, as provided below, no later than 5 p.m. on September 30, 2004.

**ADDRESSES:** You may mail nominations for membership to the following address: Centers for Medicare & Medicaid Services, Office of Clinical Standards and Quality, Attention: Michelle Atkinson, 7500 Security Blvd., Mail Stop: Central Building 1-09-06, Baltimore, MD 21244.

A copy of the Secretary's Charter for the Medicare Coverage Advisory Committee can be obtained from Maria Ellis, Office of Clinical Standards and Quality, Centers for Medicare & Medicaid Services, 7500 Security Blvd., Mail Stop: Central Building 1-09-06, Baltimore, MD 21244, or by e-mail to [mellis@cms.hhs.gov](mailto:mellis@cms.hhs.gov). The charter is also posted on the web at <http://www.cms.hhs.gov/mcac/8b1-1.asp>.

**FOR FURTHER INFORMATION CONTACT:** Michelle Atkinson, 410-786-2881.

#### SUPPLEMENTARY INFORMATION:

##### Background

On December 14, 1998, we published a notice in the **Federal Register** (63 FR 68780) announcing establishment of the Medicare Coverage Advisory Committee (MCAC). The Secretary signed the initial charter for the Medicare Coverage Advisory Committee on November 24, 1998. The charter was renewed by the Secretary and will terminate on November 24, 2004, unless renewed again by the Secretary.

The Medicare Coverage Advisory Committee is governed by provisions of the Federal Advisory Committee Act, Pub. L. 92-463, as amended (5 U.S.C. App. 2), which sets forth standards for the formulation and use of advisory committees, and is authorized by section 222 of the Public Health Service Act as amended (42 U.S.C. 217A).

The MCAC consists of a pool of 100 appointed members. Members are selected from among authorities in clinical medicine of all specialties, administrative medicine, public health, epidemiology and biostatistics, methodology of trial design, biologic and physical sciences, health care data and information management and analysis, the economics of health care, medical ethics, and other related professions. A maximum of 88 members are standard voting members, 12 are nonvoting members, 6 of whom are representatives of consumer interests, and 6 of whom are representatives of industry interests.

The MCAC functions on a committee basis. The committee reviews and evaluates medical literature, reviews technology assessments, and examines data and information on the effectiveness and appropriateness of medical items and services that are covered or eligible for coverage under Medicare. The Committee works from an agenda provided by the Designated Federal Official that lists specific issues, and develops technical advice to assist us in determining reasonable and necessary applications of medical services and technology when we make national coverage decisions for Medicare.

A few vacancies exist on the current MCAC roster, and terms for some members currently serving will expire in 2004. Accordingly, we are requesting nominations for both voting and nonvoting members to serve on the MCAC. Nominees are selected based upon their individual qualifications and not as representatives of professional associations or societies. We have a

## APPENDIX 2 - Foodborne Diseases Active Surveillance Network (FoodNet)

### Specific Activity Details

ALL applicants should propose this activity. CDC expects to provide support for FoodNet activities in all EIPs, although some FoodNet activities are expected to be conducted only in certain sites.

**a.** FoodNet activities that should be proposed by all applicants:

- 1) Conduct active, population-based surveillance for laboratory-confirmed Salmonella, Shiga toxin-producing E. coli (STEC), Campylobacter, Shigella, Listeria, Yersinia, Vibrio, Cryptosporidium, and Cyclospora infections. Complete case report forms for each case, including collection of demographic and outcome information. Collect information on foreign travel and outbreak-association on all or a statistically representative portion of E. coli O157 and Salmonella cases. Completeness of case ascertainment should be verified by audits of every clinical laboratory within the FoodNet surveillance area at least twice a year. In these clinical

laboratory audits, records in each laboratory should be reviewed and case report forms should be completed on cases not identified through the routine surveillance, as described in the FoodNet performance standards.

- 2) Submit data to CDC in a consistent and comprehensive way to allow monitoring of changes in disease incidence and tracking of progress to Healthy People 2010 national health objectives.

Additional FoodNet core activities are:

- 3) Active surveillance for cases of hemolytic uremic syndrome (HUS) ascertained through pediatric nephrologists; selected sites may also validate surveillance for pediatric HUS cases and identify adult HUS cases by review of annual hospital discharge data;
- 4) Conduct cohort study of persons infected with STEC;
- 5) Active participation in PulseNet including: pulsed-field gel electrophoresis (PFGE) of all *E. coli* O157 and *Listeria* isolates from the catchment area;
- 6) Submission of isolates to the National Antimicrobial Resistance Monitoring System (NARMS): send from State Public Health Laboratory to CDC all *Salmonella*

Typhi, non-cholerae Vibrio, and Listeria; every twentieth Shigella, Non-Typhi Salmonella, and E. coli O157; and one Campylobacter isolate per week from designated laboratories;

- 7) Participation in the Retail Food Study;
- 8) Use expanded case report form developed by Outbreak Working Group and approved by CSTE to interview all persons with listeriosis;
- 9) Enhanced outbreak investigation; report all foodborne disease outbreaks to CDC monthly using the Electronic Foodborne Outbreak Report System (EFORS); complete and submit to CDC the supplemental form to the Outbreak reporting form;
- 10) Active participation in Steering Committee calls, Working Group calls, and Coordinator calls;
- 11) Required attendance at FoodNet's annual Vision Meeting.

**b. FoodNet activities that may be proposed by interested applicants:**

The infrastructure for FoodNet and related activities is intended to be available for additional special activities including:

- 1) Completion and analysis of case-control studies of

- infant Salmonella and Campylobacter infections (at sites where this is ongoing);
- 2) Continued participation in the Enterococcus antimicrobial resistance study of outpatient stool samples. Each month participating sites send enterococci isolates to CDC for antimicrobial testing (at sites where this is ongoing);
  - 3) Completion and analysis of the Reactive Arthritis Study (at sites where this is ongoing);
  - 4) Completion and analysis of the Giardia case-control study (at sites where this is ongoing);
  - 5) Participation in toxoplasmosis surveillance (at sites where this is ongoing, or interested sites);
  - 6) Development and implementation of a study on the human health consequences of antimicrobial-resistant foodborne diseases (interested sites);
  - 7) Participation in laboratory survey and retail food study to understand regional differences in the incidence of laboratory-confirmed Campylobacter infections (interested sites);
  - 8) Conduct surveillance for cases of Guillain Barré Syndrome using hospital discharge data (interested sites);
  - 9) Development and implementation of a case-control

- study for Salmonella Javiana (interested sites);
- 10) Interview patients with laboratory-confirmed Shigella infections to determine the proportion likely to be foodborne (interested sites);
  - 11) Development and participation in a study designed to validate the proportion of persons with gastroenteritis that seek medical attention and submit a diagnostic specimen (interested sites);
  - 12) Development and implementation of a study to better understand why incidence rates of some foodborne diseases are higher in young children (interested sites);
  - 13) Implementation of molecular subtyping of norovirus strains using RT-PCR amplification and nucleotide sequence analysis.

**DRAFT**  
**Emerging Infections Programs FTP Site Interim Policy**

**Background:**

The Emerging Infections Programs sites gather data from various EIP activities, which are regularly transmitted to CDC. Historically, data files were transferred to the activity coordinator at CDC as zipped, password protected attachments to emails. Recently implemented security regulations prohibit these types of files from coming through firewalls. As a consequence, the EIP activities started to use FTP sites for data exchange. The reasons for using an FTP site are to:

- Provide secure bi-directional transfer of data
- Simplify the work flow

As the new EIP Respiratory Diseases Activity (RDA) develops, it will require a means of exchanging data similarly to FoodNet, ABCs and other EIP projects. Considering the goals of assuring security and efficiency in exchange of data between CDC and its EIP partners, and taking into account the technical approaches readily available to us, we are implementing an EIP FTP site and policy, as described below. Specifically, this approach will limit the burden on EIPs in the number of FTP sites, user ids, and passwords they have to keep track of. Meeting longer term Public Health Information Network (PHIN) objectives will involve secure, standards-based messaging for exchange of data between CDC and partners. However, the public health infrastructure at states and at CDC is not yet fully operational, necessitating this interim FTP approach.






**Function of FTP:**

An FTP site is a place to download or upload documents, files, and programs and store them temporarily. This site will be used to exchange files between appropriate personnel at CDC and the EIP sites. An ID code and password are required to log into the FTP site. As the ID code is not tied to a particular individual, several people can use the same ID and password.

**Policy:**

**EIP SITE side:**

CDC will provide a single user id and password to each EIP site, which will allow access to the state EIP folder and the project sub-folders (see below). Each state folder will contain a sub-folder for each activity, e.g., an ABCs folder, a RDA folder, a FoodNet folder. When the staff at an EIP site opens the FTP site with its id and password, the following screen will appear.

Name ▲	Size	Type	Modified
 ABCs		File Folder	9/29/2004 10:39 AM
 FoodNet		File Folder	9/29/2004 10:39 AM
 RDA		File Folder	9/29/2004 10:39 AM
 Hepatitis		File Folder	9/29/2004 3:52 PM
 Other		File Folder	9/29/2004 3:52 PM

The EIP staff at the sites can put information in or take information from each of these subfolders. To avoid misunderstandings as to which activity the data file is destined for, no files should be placed in the root directory.

The security of any FTP site is inversely related to the number of people that have access to its user id and password. EIP sites should ensure the security of the FTP site by limiting the number of people who have access to the site, keeping track of who has access, and having a written policy for access to and use of the FTP site (see suggested best practices below).













The security of the FTP site is also inversely related to the length of time a file resides on the FTP site. To minimize the time files reside on the FTP site, EIP site staff should email the appropriate CDC contact for whom the files are destined to inform them that files have been placed in the appropriate folder. Similarly, the CDC activity coordinators should notify the corresponding EIP site personnel when files have been uploaded onto the so they can be downloaded and removed.

All files placed on the FTP site should be password protected to prevent accidental unauthorized access and zipped to conserve space on the FTP site.

#### **CDC side:**

CDC will have a single user id and password for the EIP FTP site and separate passwords for the activity subfolders. To provide appropriate security, CDC will limit password access to the site and the folders. The coordinator for each of the activities – e.g., ABCs, FoodNet, RDA - will have password protected access to the folder for their activity. In addition, an FTP site administrator in the NCID Office of Surveillance will have access to all the state folders and all the sub-folders.

When an authorized user opens the FTP folder, the following screen will appear:

Name ▲	Size	Type	Modified
 CA		File Folder	9/29/2004 3:54 PM
 CO		File Folder	9/29/2004 3:54 PM
 CT		File Folder	9/29/2004 3:54 PM
 GA-GOA		File Folder	9/29/2004 3:54 PM
 GA-MSA		File Folder	9/29/2004 3:54 PM
 MD		File Folder	9/29/2004 3:54 PM
 MN		File Folder	9/29/2004 3:55 PM
 NM		File Folder	9/29/2004 3:55 PM
 NY		File Folder	9/29/2004 3:55 PM
 OR		File Folder	9/29/2004 3:55 PM
 TN		File Folder	9/29/2004 3:55 PM
 TX		File Folder	9/29/2004 3:55 PM

Within each state folder will be the EIP activity subfolders, as shown below. CDC activity coordinators will have password protected access to the appropriate sub-folders. For example, when the ABCs coordinator double clicks on a state folder, only the files in the ABCs sub-folder will be available.

Name ▲	Size	Type	Modified
ABCs		File Folder	9/29/2004 10:39 AM
FoodNet		File Folder	9/29/2004 10:39 AM
RDA		File Folder	9/29/2004 10:39 AM
Hepatitis		File Folder	9/29/2004 3:52 PM
other		File Folder	9/29/2004 3:52 PM

When information needs to be transported from the CDC to an EIP site, the coordinator will place the zipped and password protected file in the state folder. The coordinator will email the person for whom the information is destined as well as the site's data coordinator

The NCID Office of Surveillance administrator will go through all folders on a regular basis to ensure that all files in the folders have been removed by the sites. The default state of the folders and subfolders is empty. The FTP site should be in this default state 99 % of the time.

### **Suggested best practices:**

The best way to keep the data on the FTP secure is to limit the number of people with access to the site, balancing security and efficiency. What will work best for each EIP site depends on the structure and data flow at each site. The optimum number of people at a site probably should be 6 or fewer. In general, files should not stay longer than 72 hours on the FTP site. Each EIP site should have a written security and use policy covering access to the EIP FTP site. Each site should keep an up to date list of persons with access to the site and should change passwords periodically to keep appropriate access current.

**HUS/STEC Working Group  
Thursday, September 9<sup>th</sup>  
12-1pm Eastern**

**Next HUS/STEC Working Group Call:      Thursday, October 14<sup>th</sup>  
12-1pm Eastern**

**Roll**

CA      Sam Shin, Duc Vugia  
CO      Steve Burnite  
CT      Sharon Hurd, Ruthanne Marcus  
GA      Stepy Thomas  
MD      Melanie Megginson  
MN      Kirk Smith  
NM      Karen Edge, Karen Johnson  
NY  
OR      Bill Keene, Beletshachew Shiferaw  
TN      Tim Jones  
CDC      Fred Angulo, Bill Bibb, John Dunn, Patty Griffin, Cindi Snider, Drew Voetsch  
FDA  
USDA

**Minutes**

**1. Update on *E. coli* O157 Cohort Study**

- a. Anticipate sending the protocol and questionnaire into clearance during the week of Sept 13<sup>th</sup>. At the same time, will distribute the documents to the sites for comments. Plan to submit the documents to IRB once revisions have been made. Will talk to Nancy Strockbine to clarify a few issues related to the CDC laboratory

**2. Serum Collection and Testing for HUS cases**

- a. FoodNet has had a standing request from sites to submit serum when they are available. As the group is beginning to encourage more sites to submit specimens and the CDC Lab has agreed to run tests at increased frequency and to test for non-O157 STEC (possibly 5-6), this may be a good time to reevaluate our efforts in obtaining serum from HUS cases, i.e. should serum collection become a formal part of HUS surveillance and if so, we would need to submit the protocol to IRB. Possible reasons to formalize collection include IRB requirement in some sites and the use of a test that is not FDA approved.
  - i. Although a few of the sites are able to collect serum as part of routine surveillance activities (MN, OR, TN) a couple of sites (CT, NM) require IRB approval.
    1. TN was confident that testing was a service provided within public health practice
    2. If the protocol were to be submitted to CDC IRB, all sites would have to submit the protocol to their state IRB. This would add an additional layer for sites that can collect and test serum through routine surveillance.
  - ii. Laboratories have had requests for "stat results". This is not possible and concerns arose that physicians may not realize that the serology tests are not FDA-approved and should not be used for patient care. Although results are sent with such a disclaimer, there may still be some miscommunication. Issue is if this test is considered research. If yes, serum would be considered part of the research and would be subject to IRB review.
- b. One suggestion was not to formalize serum collection in HUS surveillance but rather have a study to evaluate the tests used by the CDC lab. Sites that were interested in participating could collect serum from all cases, regardless of stool culture result, for 12 months. The study would provide the CDC with large numbers of sera to test and would allow the lab to assess the specificity, sensitivity and positive predictive value of its test.

In addition, this study would be open to all states, not just FoodNet sites. During the study, serum collection for HUS surveillance would cease. Once the study was finished and based on its findings, serum collection could be reintroduced into surveillance activities.

- i. CDC Lab liked the idea of the study and has offered to look into making this test a CLIA approved test
  - ii. TN and MN voiced their concern about ceasing submission of sera for routine surveillance. Testing is a service offered to all the states by the CDC Lab and a substantial portion of their HUS cases are identified to have *E. coli* O157 through serology testing.
  - iii. CO raised the issue that a number of litigations occur as a result of *E. coli* O157 outbreaks and lawyers want to obtain the results for their lawsuit. It would be preferable to say that the test is either research or is truly diagnostic.
- c. The group is still in the early stages of discussion for serum collection and testing so no decision was made. CDC FoodNet will explore the IRB issue and bring the information to the next call

### **3. Adult HUS Surveillance**

- a. Most adult cases are ascertained through passive surveillance and hospital discharge data. Will move to standardize the approach by having states continue to receive passive surveillance reports but also to complete HDD reviews in a time frame that is reasonable for the site.
- b. Cindi will draft a description of adult HUS surveillance activities and circulate for the next call

### **4. CT's Draft STEC Fact Sheet**

- a. CT circulated a STEC fact sheet that they have drafted. Please feel free to send comments to Sharon ([sharon.hurd@yale.edu](mailto:sharon.hurd@yale.edu)) or Cindi ([bex4@cdc.gov](mailto:bex4@cdc.gov))

### **5. Other Issues**

- a. Eileen Dunne's manuscript on pediatric HUS was submitted to JAMA on August 16<sup>th</sup>.
- b. Cindi will have a poster at IDSA on adult D<sup>+</sup> HUS. She will share the poster with the working group.

## **Hemolytic Uremic Syndrome (HUS) Surveillance and IRB**

### **Background**

The issue of Hemolytic Uremic Syndrome (HUS) surveillance and IRB was initially raised at the beginning of HUS Surveillance in 1997. Specific concerns raised included the use of a serologic assay that was not FDA approved and the use of serum without patient consent.

### **Discussion**

On September 16<sup>th</sup>, 2004, the HUS Surveillance Coordinator and the FoodNet Coordinator spoke with NCID's IRB liaison about the issue of serum testing for surveillance purposes. The following were points raised and addressed during the conversation.

#### **1. Use of a non-FDA Approved Test**

According to NCID's IRB liaison, most tests at CDC are not FDA approved tests. The status of a test (FDA approved or not) is not an issue of concern and is not a factor in considering if a project or surveillance activity is research. Of note, disclaimers are sent with results indicating the test results should not be used for clinical treatment purposes.

#### **2. Use of Serum**

According to NCID's IRB liaison, the use of leftover serum is allowed. However, if sites draw blood from individuals explicitly for the purpose of HUS surveillance in FoodNet, this opens the question of intent. If sites draw blood for testing, FoodNet will need to provide an explanation to CDC's IRB about the intent of testing.

#### **3. State IRB Reviews**

According to NCID's IRB liaison, site specific IRBs are permitted even if CDC does not have IRB. However, if sites require informed consent from a patient, this would constitute an activity different from CDC, which does not obtain informed consent. This would also differ from other states that do not required informed consent. Obtaining informed consent from patients would open the possibility for research and would need to be reviewed more carefully by CDC's IRB.

### **Conclusion**

As noted by NCID's IRB liaison, collection and testing of serum is part of routine surveillance. Sites may volunteer to have specimens sent to CDC for testing, irrespective of FDA license. It was concluded that current HUS surveillance activities constituted surveillance and not research.



## Memorandum

To: Director, Office of Disease Prevention and Health Promotion

From: Elisa L. Elliot, Ph.D. (FDA Center for Food Safety and Applied Nutrition, and  
Delila Parham, DVM, (USDA Food Safety and Inspection Service)

Date: May 26, 2004 (Note: Baseline and target revised 10-4-04. ELE)

Re: HP2010 Objective 10-1f: Request Move to Measurable Status

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**Objective 10-1 Reduce infections caused by key foodborne pathogens.**

**10-1f. (Developmental) Hemolytic Uremic Syndrome, postdiarrheal**

- ◆ Postdiarrheal hemolytic uremic syndrome (HUS) is a life-threatening illness characterized by hemolytic anemia, thrombocytopenia, and renal injury. Because there are no diagnostic tests specifically designed for HUS, surveillance efforts rely on recognition of the syndrome by physicians.
- ◆ HUS can occur in persons of any age. The syndrome of HUS is fairly distinctive in children and HUS is the major cause of acute renal failure in this age group. Death occurs in 5% of children and a larger proportion of the elderly with HUS.

**Proposed Change**

- ◆ The Food Safety Work Group recommends moving the objective from developmental to measurable status, with a slight revision in the wording of the objective.
- ◆ The proposed objective is: "Reduce cases of postdiarrheal hemolytic uremic syndrome (HUS) in children less than 5 years of age."
- ◆ .[Note: For the Midcourse Review the Work Group has been asked to use data from 2000 for the baseline. Thus, the following sentence will be changed from: "The 1997 baseline is 1.36 cases per 100,000 children under age five and the 2010 goal will be a 50% reduction to 0.7 cases per 100,000." to "The 2000 baseline is 1.8 cases per 100,000 children under age five and the 2010 goal will be a 50% reduction to 0.9 cases per 100,000."
- ◆ Data for objective 10.1 are from the Foodborne Diseases Active Surveillance Network (FoodNet), which was established in 1996. FoodNet is an active, population-based surveillance system designed to determine more precisely the burden and severity of foodborne illnesses, and to identify the sources of specific foodborne diseases. FoodNet is a collaborative activity of the CDC, the Food and Drug Administration (FDA), the Food Safety and Inspection Service (FSIS) of the U.S. Department of Agriculture (USDA), and ten states (California, Colorado, Connecticut, Georgia, Maryland, Minnesota, New Mexico, New York, Oregon, and Tennessee).
- ◆ Crude incidence rates are generated for HUS. This analysis is restricted to HUS-diagnosed patients who reside in the FoodNet catchment area and are less than five years of age.

**Justification for Change**

- ◆ The objective will be measurable if the modification is approved.
- ◆ Sufficient, nationally representative data from FoodNet are now available to move this objective from “developmental” status to “measurable,” and the available data are provided in the data table:

Year	HUS cases per 100,000 population under 5 years	HUS cases per 100,000 population of females under 5 years	HUS cases per 100,000 population of males under 5 years
Baseline (1997)	1.36	1.12	1.6
1998	1.85	2.77	1.16
1999	1.30	1.62	1.11
2000*	1.80	2.39	1.71
2001	1.44	2.24	0.91
2002	1.91	2.07	1.90

**Change Supported By:**

- ◆ CDC, FDA and FSIS participated in proposing this change.
- ◆ Departmental Liaisons that reviewed and approved this change:
  - NCHS ☒
  - ODPHP ☒
- ◆ The need for this change in this developmental objective was relayed to the Mid Course Review committee in July, 2003, and was discussed during the Healthy People 2010 Food Safety Data Progress Review on May 11, 2004.

Item	Discussion	Action Items
<b>Population Survey Cognitive Juice Survey</b>	The preliminary report was sent out last week. There was a discussion by Elaine about the results. The survey is not so important for quantitative value at this point, as the qualitative. Its purpose was as a practical way to clarify questions before launching into the larger survey.	Elaine: Next step is to design the questionnaire and pilot it.
<b>Salmonella and Reptiles Project</b>	1) A MPH practicum student will develop an online survey with FoodNet staff for reptile clubs and pet stores re: knowledge of <i>Salmonella</i> and where they obtain information on reptile health/ husbandry. She graduates in December, thus deadline for the project. Heather and Stacy are still discussing which clubs/stores will be sampled. The student will make visits to pet stores in the metro Atlanta area to see what's displayed for education materials. 2) A visiting vet student, Sarah Mills, will update Healthy Pets, Healthy People website 3) Heather had a conference call with Pet Industry Joint Advisory Counsel re: revising posters about CDC guidelines for preventing reptile-associated salmonellosis. PIJAC does not want to revise until the old posters are gone. 4) A CDC EIS officer will be working on a project to look at reptile-associated <i>Salmonella</i> infections. There were suggestions to make comparisons between states with mandatory education for persons purchasing reptiles.	Heather and Stacy:  Work with student on project survey development and sampling.  Mid-October conf call with Pet Industry Joint Advisory Counsel re: revising posters.  Sarah will work on website
<b>Nursing Home Survey Update</b>	Nursing home survey protocol and questionnaire have received IRB exemption. We can only make minor changes to modify the letter, protocol, etc. to modify to a state-specific format. If it's in the protocol, then OK to put in the letter. States should forward questions about modifications to Jennifer Nelson.  There was a question about putting together a list of facilities to be surveyed. Glenda Lewis (FDA) will generate the lists to be distributed to individual states. Start dates will stagger as each state may start upon receiving IRB approval, but should follow the same timelines as outlined in the protocol for reminder calls, follow-up mailings, etc.. CO and CA have state IRB-approval. Sampling: NY to all homes in the FN county catchment areas. MN not participating -states and CDC will need to amend protocols	Jennifer: will send protocol out to sites again and in word document format. Check with CDC IRB about amendments to protocol and email info.  Each state: Send a copy of IRB approval to CDC.  Karen and Glenda: generating list of facilities to send to JN for distribution beginning of next week. Karen has a grad student building Access database, which will be distributed when complete.
<b>Tertiary Care Survey</b>	The question was asked to states how they'd like to see the survey modified. One objective of the survey would be to assess what guidelines/policies facilities follow for food handling, and for specialty populations of immunocompromised. What topics are states interested in and hospital populations should we look at? There was a comment that irradiated meat is not relevant in all states. Also, a survey has been done on this in	Each state: Determine what state regulations exist? Start thinking about sampling- hospital size, patient mix, special units, etc.  Julie: will talk with Infection Control about

	CT. Other suggestions included expanding on hospital policies and immunocompromised (e.g., flowers, food brought in from outside). Glenda: there are state regulation food codes we'd want to find out about for each state. JCAHO guidelines are vague. Hospital Infection Control departments may write their own facility-specific guidelines. We will need to gather more info to focus research question.	national guidelines and CDC group to focus research question. Possible visit to hospital. Glenda: will contact CMS . Ruthanne: Will contact Jim Hadler re: info he gathered on regulations.
<b>NEXT CALL</b>	<b>Tuesday, October 26, 2004 (2:00-3:00 pm EST)</b> <b>Number: 866-741-7180      PassCode: 201705</b>	

**Outbreak Working Group**  
**Thursday, September 16<sup>th</sup>, 2004**  
**3-4pm Eastern**

**Next Call: Thursday, October 21<sup>st</sup>, 3-4pm Eastern**

**Roll**

\*Due to the limited number of call lines that were available for this call, all states and agencies will be considered present for this working group call. Arrangements have been made to ensure call lines will be available for everyone in the future.

**Agenda**

**1. Update on Outbreak Variable in FoodNet Active Surveillance Data**

- a. Tables will be changed to *Salmonella* and *E. coli* O157 infections rather than all pathogens
- b. An updated table will be provided at the October call to reflect these changes and to address any reporting issues

**2. Isolate Submission Guidelines for *Salmonella* Outbreaks-Draft**

- a. In the event of a multistate *Salmonella* outbreak, we would minimize the number isolate requests to states by approaching the state with the most laboratory confirmed cases
  - i. However, if a FoodNet site is involved in the outbreak and has 3 or more laboratory confirmed cases, the FoodNet site will be asked to submit isolates
- b. Proposed that FoodNet sites reduce the threshold from 3 laboratory confirmed cases to 2 laboratory confirmed cases. CDC will check with NARMS to make sure this will be feasible
- c. Will try to finalize the draft during the next call but sites should submit isolates to Cheryl Bopp in the Outbreak Laboratory if isolates are requested in the interim

**3. Update on Non Foodborne Outbreaks**

- a. A template was sent to the non-foodborne subgroup that included the data to be collected, formats, and description
- b. Marc Alain requested that sites participating in this subgroup submit their 2004 data for the first 6 months
- c. Analysis for this subgroup has been pending upon receipt of the 2002 finalized data

**4. Update on OB Project-EFORS Contributing Factors**

- a. The subgroup has provided the OB working group with a copy of the proposal that will be submitted for the October Steering Committee call
- b. The first step of the proposal will be to look at the quality of the EFORS contributing factors data from FoodNet sites between 1998-2002. The group may also propose recommendations for improving the collection of

these data in the FoodNet sites. Eventually, the group may transition to the Outbreak Unit where they can explore the quality of the EFORS contributing factors data nationwide.

- c. A number of interested organizations are involved in the subgroup including EHS-Net, FDA, USDA, FoodNet and the Outbreak Unit. Anyone interested in joining the working group should contact Cindi at [bex4@cdc.gov](mailto:bex4@cdc.gov)

#### **5. Update on OB Project-*Salmonella* Incubation Period**

- a. The subgroup hopes to schedule a call in the next few weeks to discuss the project
- b. Bill Keene had circulated a number of questions and issues to the subgroup for consideration and discussion on the conference call

#### **6. Update on National Epi Meeting**

- a. The meeting has been scheduled concurrently with the PulseNet Meeting from May 9<sup>th</sup>-11<sup>th</sup>, 2005 in Seattle
- b. Some sessions will be a joint session with PulseNet while some sessions will be just for the epidemiologists
- c. There is no funding for travel or per diem but this may be a good use of ELC funds, especially for training
- d. The OB Unit would like to invite the working group to help set the agenda for the meeting. The OB Unit will also elicit help from USDA and FDA separately
  - i. Tim suggested that everyone think of ideas for the agenda and to bring your ideas to the October working group call. The group can pool ideas and discuss priorities before making suggestions to the OB unit

#### **7. Timeliness of Multistate Outbreak Investigations**

- a. In recent months, there have been a number of *Salmonella* clusters that have been identified through PulseNet. Some investigations have been successful and some have been not so successful. One issue that has emerged is the lack of timeliness in obtaining information. This has impaired a number of case control studies. The OB Unit was interested in hearing ideas or methods in which they could document instances in which investigations have not been successful. One idea was to bring this issue to the National Epi meeting in Seattle and to show the data, but what are the data? What would be useful for states to hear at the meeting to highlight this problem?
  - i. TN suggested presenting specific examples by laying out what happened during the investigation
  - ii. Suggestion that a guideline be developed to help states identify when they will need cooperation and support from neighboring states or CDC. States could also use these guidelines to argue for more money or resources

- iii. Suggested that states present problems they have had with other states but this may also hurt state-state relationships
  - iv. Suggested the OB Unit come up with performance standards for outbreak investigations and publish the results
  - v. OR suggested that the PulseNet data be examined. Since there have been a number of clusters recognized, it would be helpful to see how many clusters there were, how many were investigated and how many turned out to be an outbreak. From there, could see how many successfully identified a source
  - b. Anyone with any other ideas should pass them on to Chris Braden ([CRB5@cdc.gov](mailto:CRB5@cdc.gov)). Will further discuss this issue on next month's call
8. Other Issues
- a. There were no other issues brought to the call

## **Minutes for the July FoodNet Coordinators Call**

### **Thursday, August 19, 2004**

**Attendees:** Sam Shin (CA), Nicole Haubert (CO), Sharon Hurd (CT), Melissa Tobin-D'Angelo, Stepy Thomas (GA), Pat Ryan (MD), Ellen Swanson (MN), Karen Edge (NM), Shelley Zansky, Bridget Anderson, Dina Hoefer (NY), Melissa Plantenga (OR), Tim Jones (TN), Linda Gaul (TX), Jennifer Nelson, Alison Drake (CDC)

#### **Action Items for August:**

1. **Everyone:** If you haven't already, please provide Jennifer with the list of persons to include in the "2003 FoodNet Working Group";
2. **MN, NM, NY, OR, TN, TX:** Just a reminder that you'll be updating us on a project/study/question/challenge on which your site is working.

#### **July Discussion:**

##### **1. NEDSS:**

- It is not possible to have "turn on/off" fields for FoodNet specific variables in NEDSS as this is a logic-based function and the Foodborne PAM fields are collaboratively based
- FoodNet CDC is holding a meeting with CDC's Office of Surveillance to work out a mechanism to address NEDSS concerns

##### **2. Performance Standards:**

- Draft performance standards for travel and outbreak variables were distributed and comments were provided
- Changes will be made and presented to the Steering Committee in September

##### **3. Site-specific updates:**

###### **California:**

- Have set-up proactive protocol for serum collection in HUS patients
- Sparked by HUS case with had a negative O157 culture
- Protocol was not successful with this case because case was discharged but CA was successful in setting-up system for proactive sample collection
- Working on mechanisms to access county records to obtain better travel history and race/ethnicity data; Challenging but should be worthwhile
- Have been hit with several outbreaks, including a *S. Typhimurium* outbreak
- Working on hypothesis generating questionnaires
- In the process of training several new staff members

###### **Colorado:**

- Following an O157 cluster in the FoodNet catchment area

- 4 cases, all male, all at rare steaks from the same chain restaurant
- Steaks were needle-tenderized products; working with USDA on recall
- Reviewing report from similar outbreak in MN

#### **Connecticut:**

- Working to get better follow-up information from counties which interview cases, especially for travel information variables
- Involved in a multi-state *S. Braenderup* outbreak
- Recent lab report of positive blood-culture for *Salmonella* but never received state confirmation
- Looked into this case and found it was serum that was tested for *Salmonella* antibodies
- Before last year, had never seen this type of case before; could be trend in CT
- GA has also receives reports of positive serum test
- These cases should not be included in FoodNet surveillance

#### **Georgia:**

- S. Javiana* a FoodNet priority from the 2004 Vision Meeting
- Have developed and implemented a hypothesis generating questionnaire; launched early August
- Will interview all *S. Javiana* cases (~200/year)
- Had *Vibrio vulnificus* with no know oyster exposure, only shrimp and crab exposure; immunocompromised
- Rare because case only had GA water exposure and *Vibrio vulnificus* typically not seen in GA waters
- TX has lots of wound infections associated with brackish waters; all have immunocompromising conditions
- ABCs coordinator is leaving. Since many responsibilities are shared between the FoodNet and ABCs group, some FoodNet resources will be diverted.

#### **Maryland:**

- Have hired a new FoodNet epidemiologist
- Working on outbreak that occurred at national leadership convention
- Have new initiative in collaboration with University of Maryland.
- Student has geocoded 2-3 years worth of Maryland FoodNet data
- Have abstract accepted at national conference
- Data show disease occurs where people live; working on additional analyses

## Attributions working group minutes, 2003

7 October 2004; 11 a.m. EST

**Present:** CO-Alicia Cronquist, CT-Ruthanne Marcus, GA-Melissa Tobin-D'Angelo, NY-Dina Hoefer, OR-Paul Cieslak, TN-Tim Jones, Uni. of MN-George Maldonado, Carrie Rigdon, USDA- Alecia Naugle, Bonnie Rose, CDC- Fred Angulo, Nicole Ishill, Drew Voetsch, Elaine Scallan, Elizabeth Ailes, Cindy Snider, Jennifer Nelson, Mike Hoekstra

Item	Discussion	Plan
FoodNet site visit to Uni. of MN	Fred Angulo, Elaine Scallan, Nicole Ishill, and Kristin Holt meet with George Maldonado, Carrie Rigdon, Tim Church and Craig Hedberg at the University of MN on September 30 <sup>th</sup> . Jane Harman and Reuben Varghese joined the meeting via conference call. The agenda items were (1) Carrie's point-of-processing attribution project; (2) the Blending project proposal; and (3) case-control study analysis.	
Point-of-processing attribution project	Carrie Rigdon gave a summary of her presentation from the September 30 <sup>th</sup> , which included an overview of relevant work carried out to date (i.e. the Dutch model, the Danish Deterministic model, the Sarwari Model and the Danish Stochastic Model.) Carrie's approach will be to develop the model in a stepwise manner as follows: (1) Dutch-type model; (2) Danish Deterministic-type model; (3) Danish Stochastic-type Model (with or without Bayesian or other interpretive approach).	- Carrie Ridgon to prepare a list of questions for deliberation on the next attribution conference calls.
Blending project	George Maldonado gave a summary of the 'Blending project' proposal which aims to blend data on E. coli O157 from outbreaks and FoodNet sporadic case-control studies. The research questions are: (1) 'How many cases of E. coli O157 infection can be attributed to food, animal, water and other exposures?' (2) 'Of those cases attributed to food, how many can be attributed to specific food vehicles at the point of consumption?' This will be achieved by combining the attributable number from outbreaks and sporadic case-control studies.  As part of this project George Maldonado will undertake a review of FoodNet case-control study methods to determine how results could be corrected for study imperfections.	-George Maldonado to send Elaine Scallan his paper on correcting study bias

### Attributions working group minutes, 2003

Update on travel data	Travel tables were presented. There is a time lag with the data. Some of the missing variables are cases who have been interviewed but because of the time lag this has not yet been captured in the data. It was noted that the reporting of travel data is a performance standard.
Date of next meeting	The next meeting is scheduled for November 4 <sup>th</sup> 11AM

Steering Committee Proposal  
Centers for Disease Control and Prevention  
Emerging Infections Program  
Foodborne Diseases Active Surveillance Network (FoodNet)  
Phone: (404)-371-5465  
Fax: (404)-371-5444

Proposed by: Craig Hedberg (MN), Patrick McCarthy (FDA), and others

Title: Evaluating the reporting of contributing factors (CF) to EFORS

Submitted: September 16, 2004

Purpose: The source and quality of the "contributing factor" data reported on the electronic version of the Investigation of a Foodborne Outbreak form (CDC 52.13) will be evaluated as a first step towards improving the reporting of outbreak associated contamination factors, proliferation / amplification factors, survival factors, and method of preparation data.

Dataset: All data reported on the electronic version of the Investigation of a Foodborne Outbreak form (CDC 52.13) in EFORS for the years 1998 through 2002 for FoodNet sites.

Work Group: The study work group will be formed by a subcommittee of the FoodNet Outbreak Working Group, the proposal submitters, and interested collaborators from EHSNET, the FDA Retail Food Program and FSIS.

Timeline: Following approval of the proposal, a schedule will be developed for monthly conference calls to review progress of the study.

A draft of the preliminary analyses will be completed in 120 days after the data are received, subject to review by the work group.

Publication: A summary of the proposed analyses will be prepared for working group collaborators. If an abstract or manuscript appears warranted after initial evaluation, a revised proposal to that effect will be submitted to the FoodNet Steering Committee. The Data Use Policy for this proposal includes collaboration with and approval for dissemination from the Outbreak Response and Surveillance Unit, Foodborne and Diarrheal Diseases Branch, CDC.